

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6402 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 06396

1. PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>AA</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b <i>10</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Bembes Pt.</i>		d. STREET ADDRESS <i>Bembes Pt.</i>	
3. NAME OF DECEASED (Type or print) First <i>ERNEST EDWARD</i> Middle <i>ADAMS</i> Last <i>SR.</i>		4. DATE OF DEATH Month <i>6</i> - Day <i>19</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar. 28th 1881</i>
9. AGE (In years last birthday) <i>77</i> yrs.		10. IF UNDER 1 YEAR Months <i>7</i> Days <i>7</i> Hours <i>19</i> Min.	11. IF UNDER 24 HRS. Months <i>7</i> Days <i>7</i> Hours <i>19</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Engineer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S.</i>	
11. BIRTHPLACE (State or foreign country) <i>Somerset Co Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Thomas B. Adams</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Mulligan</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mary E. Adams</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac disease</i> DUE TO <i>4344</i> Conditions, if any, which gave rise to immediate cause (b) <i>Sudden</i> (c) <i>INTERVAL BETWEEN ONSET AND DEATH</i> DUE TO <i>Sudden</i> cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. Linhardt</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>E. Linhardt</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-22-58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Wheatcroft</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i>		ADDRESS <i>Wheatcroft</i>	
24a. REC'D BY REGISTRAR <i>JUN 23 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Wheatcroft</i>	

CERTIFICATE OF DEATH

06397

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Laurel</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Laurel</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Children's Center</u>		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Ann</u> Middle <u>O. Andrews</u> Last <u></u>		4. DATE OF DEATH Month <u>June</u> Day <u>19</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 23, 1900</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Children's Center</u>	11. BIRTHPLACE (State or foreign country) <u>Missouri</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Edward Andrews</u>	
14. MOTHER'S MAIDEN NAME <u>F. May Allison</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Family records</u> Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 420.1 DUE TO (b) <u>Coronary Atherosclerosis</u> DUE TO (c) <u>Generalized Atherosclerosis & Hypertension</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>58</u> , to <u>June 18</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 18</u> , 19 <u>58</u> , and that death occurred at <u>6:00</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert O. Wingfield</u> M.D.		ADDRESS (Street, city or town, state) <u>Laurel, Maryland</u> DATE SIGNED <u>June 19, 1958</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT O. WINGFIELD</u>			
22a. BURIAL, CREMATION, REMOVAL, (Specify)	22b. DATE THEREOF <u>June 23, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Beachmont Chapel Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Laurel, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. W. Randolph</u> ADDRESS <u>Laurel Md</u>		24a. REC'D BY REGISTRAR <u>JUN 24 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. W. Randolph</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, and 3 should be filed with the funeral director, the funeral director, and the funeral director. Pages 1, 2, and 3 should be filed with the funeral director, the funeral director, and the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, the funeral director, and the funeral director. Pages 1, 2, and 3 should be filed with the funeral director, the funeral director, and the funeral director.

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the funeral director, the funeral director, and the funeral director. Pages 1, 2, and 3 should be filed with the funeral director, the funeral director, and the funeral director.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6426

Items 1, 13, 14, File # G231 7-3-58 et

CERTIFICATE OF DEATH

06398

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) o. STATE <i>Maryland</i> <i>Garland Park</i> <i>Anne Arundel Co</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Garland Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>near Glen Burnie Md</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>1 104 Oak Ave</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>Edward</i> Last <i>Anthony</i>		4. DATE OF DEATH Month <i>June</i> Day <i>24</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 17, 1915</i>
9. AGE (In years last birthday) <i>43 yrs.</i>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Black Smith</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Shoe repair</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Frank Anthony</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Hendricks</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>214-014824</i>	
17. INFORMANT <i>Mr. John Wolk</i>		Address <i>John 17th. Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Vascular Disease</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>3 or 4 years</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Decomposed</i> <i>Hansen</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1957</i> , to <i>June 24</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>June 24</i> , 19 <i>58</i> , and that death occurred at <i>1 P.</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James S. Bellingshale</i> M.D.		ADDRESS (Street, city or town, state) <i>108 Central Ave Glen Burnie Md</i>	
DATE SIGNED			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 27-58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Eden Hill</i>		22d. LOCATION (City, town, or County) (State) <i>Rutledge Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Blair A. Frank</i>		ADDRESS <i>Glen Burnie Md</i>	
24a. REC'D BY REGISTRAR DATE <i>JUN 26 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Alfred</i>	

CERTIFICATE OF DEATH

1923

Name of Deceased _____		Sex _____	
Date of Birth _____		Place of Birth _____	
Usual Residence _____		Date of Death _____	
Cause of Death _____		Manner of Death _____	
Signature of Physician _____		Signature of Registrar _____	
Signature of Coroner _____		Signature of Medical Examiner _____	
Signature of Burial Officer _____		Signature of Undertaker _____	
Signature of Minister of Religion _____		Signature of Cemetery Officer _____	
Signature of Health Officer _____		Signature of District Attorney _____	
Signature of County Clerk _____		Signature of State Registrar _____	

CERTIFICATE OF DEATH

06399

Reg. Dist. No.

6403

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN IB			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Anne Arundel General Hospital</u>				/d. STREET ADDRESS <u>Rt. 9, Box 345</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>"Baby"</u> Middle <u>Boy</u> Last <u>Arkuszieski</u>				4. DATE OF DEATH Month <u>June</u> Day <u>26</u> Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 26, 1958</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months		Days		Hours Min.	
						<u>2</u> <u>20</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>			
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>John Anthony Arkuszieski</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Trimble</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT <u>John A. Arkuszieski</u> (Father) Address <u>Rt. 9, Box 345, Pasadena, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>placenta previa i hemorrhage</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>6/26</u> 19 <u>58</u> , to <u>6/26</u> 19 <u>58</u> , that I last saw the deceased alive on <u>6/26</u> 19 <u>58</u> , and that death occurred at <u>6:40 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>S. Borssuys</u> M.D.				Amos G. Blevins <u>6/27/58</u>			
PHYSICIAN'S NAME (Type) <u>S. Borssuys</u>				<u>Annapolis Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 28/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Brooklyn, BFD, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Singleton</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>JUL 1 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Alberich</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1-03

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the information required by the law, and in any event within 72 hours after death.

Item 20 Film 231 7-7-58									
STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
6427									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY A.A. Co					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie					c. LENGTH OF STAY IN 1b x Glen Burnie				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 205 Harford Road					e. STREET ADDRESS 205 Harford Road				
3. NAME OF DECEASED (Type or print) First Alice Middle A Last Bailey					4. DATE OF DEATH Month June Day 22 Year 1958				
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 11-1885		9. AGE (In years last birthday) 73 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY W. Va.			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN					14. MOTHER'S MAIDEN NAME UNKNOWN				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. NONE		17. INFORMANT Ruby Bailey		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1 DUE TO ANOXIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CONGESTIVE HEART FAILURE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) METASTATIC CARCINOMA TO LIVER, 1st, 2nd, 3rd BURNS ABDOMEN & THIGHS					INTERVAL BETWEEN ONSET AND DEATH 3 DA. 3-4 YRS.				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) (Burns healed at time of death*)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from NOV. 1957, to JUNE 1958, that I last saw the deceased alive on JUNE 20, 1958, and that death occurred at 1:58 A.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE Leon C. Perry					ADDRESS (Street, city or town, state) M.D. 201 B + A BLVD, GLEN BURNIE, MD.				
PHYSICIAN'S NAME (Type) LEON C. PERRY, M.D.					DATE SIGNED 6-22-58				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF June-25-58		22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery			22d. LOCATION (City, town, or county) Princeton W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE R. V. Singletary, Glen Burnie					24a. REC'D BY REGISTRAR DATE JUN 25 '58		24b. REGISTRAR'S SIGNATURE W. B. Seabach		

WEST VIRGINIA

CERTIFICATE OF DEATH

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BATHING



[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a standard death certificate form with fields for personal information, cause of death, and a signature line.]

NAME: _____

AGE: _____

SEX: _____

DATE OF BIRTH: _____

PLACE OF BIRTH: _____

DATE OF DEATH: _____

PLACE OF DEATH: _____

CAUSE OF DEATH: _____

SIGNATURE: _____

6428

CERTIFICATE OF DEATH

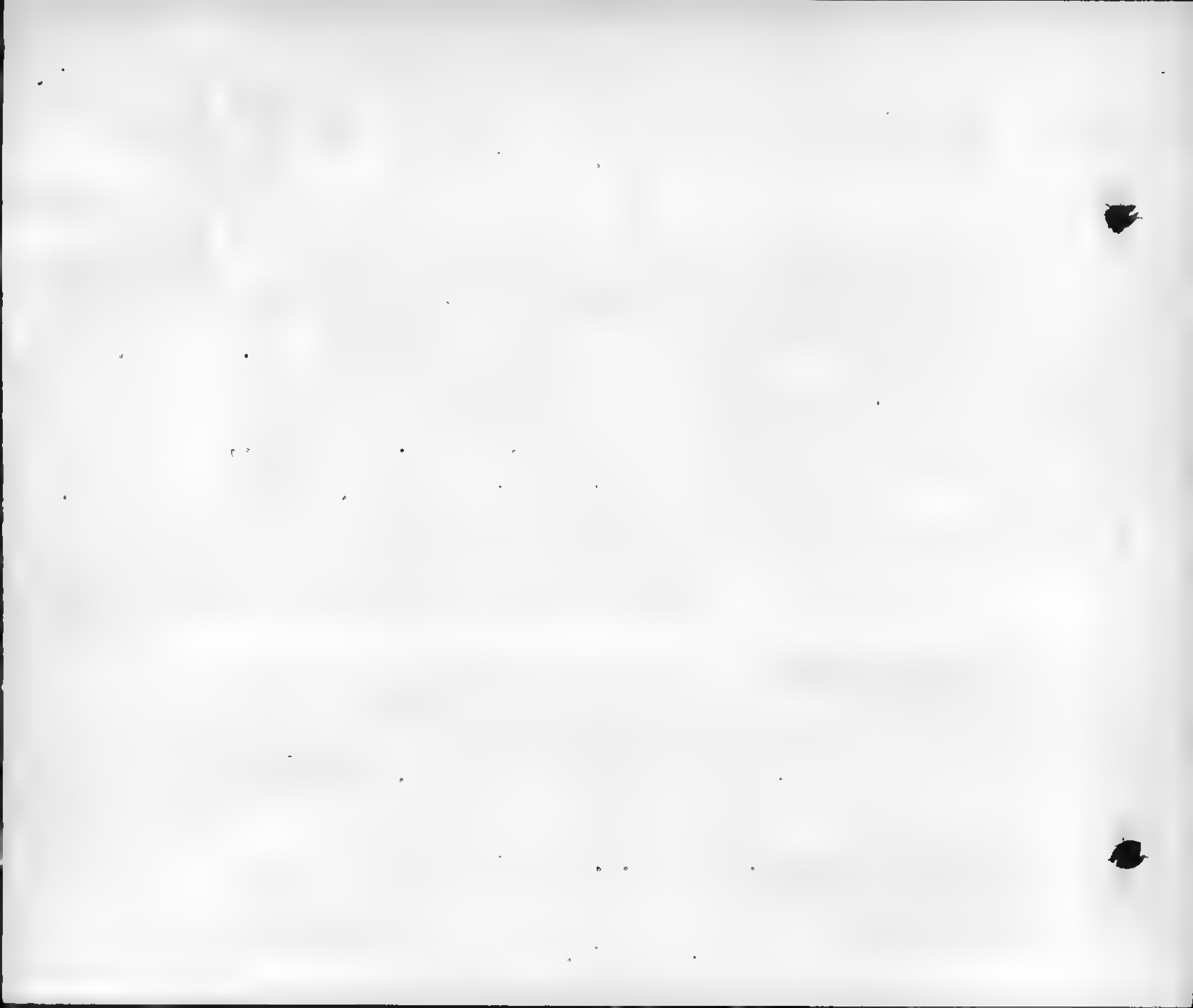
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum c. LENGTH OF STAY IN 1b 32 yrs. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 111 Sycamore Road		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Linthicum d. STREET ADDRESS 111 Sycamore Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last SARA EDITH BARNES		4. DATE OF DEATH Month Day Year June 27, 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 17/98
9. AGE (In years last birthday) 59 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Baltimore Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John O. Jones		14. MOTHER'S MAIDEN NAME Mary E. Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none	
17. INFORMANT Mr. John F. Barnes, Sr.,		Address Same As #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Carcinoma of Lt. Breast 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 1 yr. +
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 19 57 to June 27, 19 58 that I last saw the deceased alive on June 25, 19 58 , and that death occurred at 4:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Charles L. Ball, M.D. 6/27/58 PHYSICIAN'S NAME (Type) Charles L. Ball, M.D. Linthicum, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 30/58	22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.	22d. LOCATION (City, town, or county) (State) Glen Burnie, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS Glen Burnie, Md.		24a. REC'D BY REGISTRAR JUL 1 1958 DATE	24b. REGISTRAR'S SIGNATURE [Signature]

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

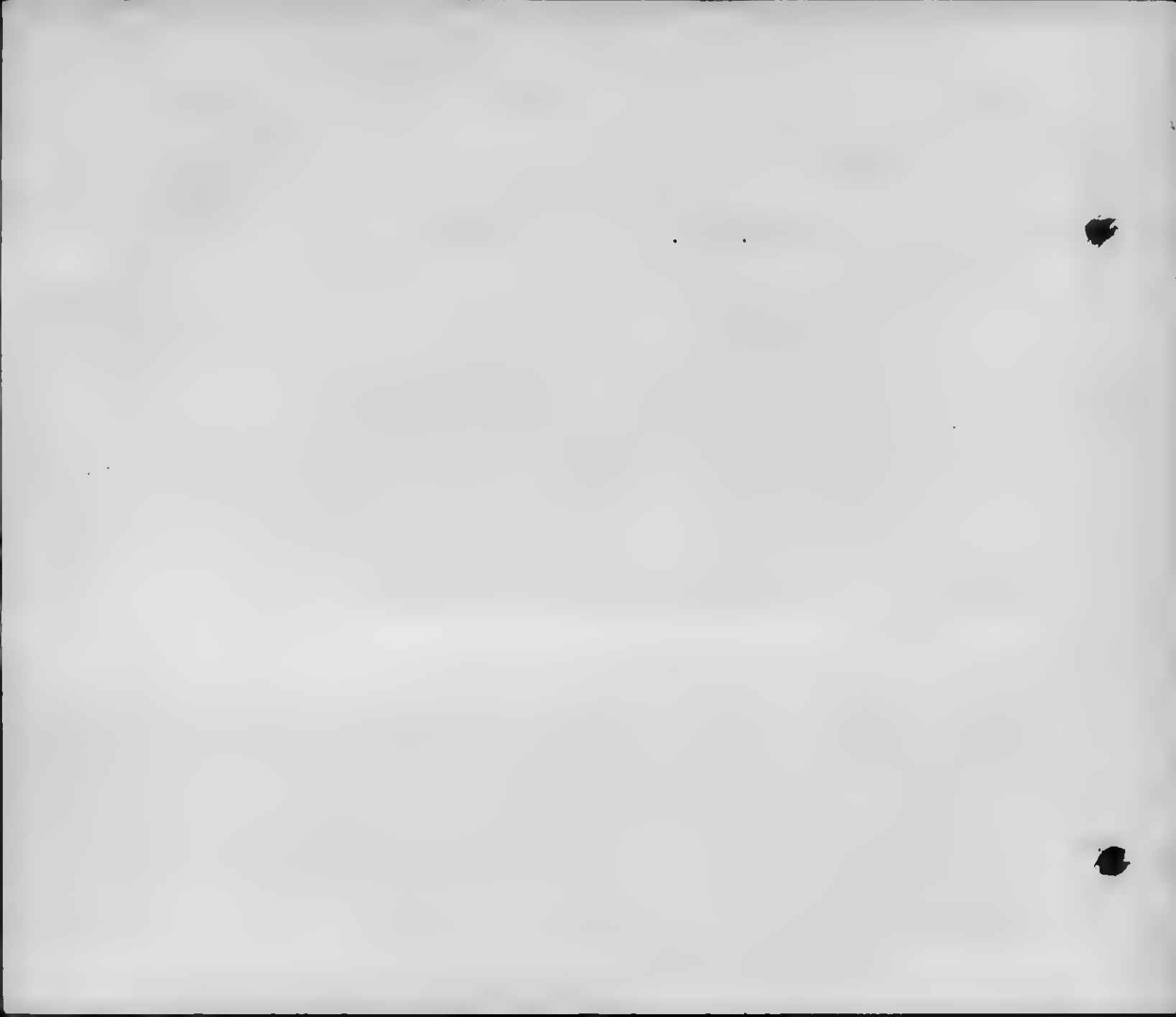
6404

06402

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

Reg. Dist.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>ANNO.</u>	MARYLAND	STATE <u>MD.</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>BALTIMORE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>A. A. Gen'l. Hosp.</u>		STREET ADDRESS (If rural, give location) <u>315 - West 31st St.</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>George</u>	(Middle) <u>A.</u>	(Last) <u>BASKIN</u>	(Month) <u>6</u> (Day) <u>19</u> (Year) <u>1958</u>
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>	8. DATE OF BIRTH: <u>Sept. 6, 1889</u>
		9. AGE last birthday: <u>68</u> yrs.	10. IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Self Emp.</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Elec. Contractor</u>	
11. BIRTHPLACE (State or foreign country): <u>S. C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Wm. M. Baskin</u>		14. MOTHER'S MAIDEN NAME: <u>Rozanna Leslie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>yes</u> <u>World War I</u>		16. SOCIAL SECURITY No.: <u>-212-22-9260</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Estelle M. Baskin - 315 W. 31st St.</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
<u>434.4</u> Immediate cause (a) <u>Heart Disease</u> DUE TO		<u>10</u>	
Antecedent cause(s) (b) <u></u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M.</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>Chas. H. Hacht</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>6-19-58</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <u>6-19-58</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>6/23/58</u>	NAME OF CEMETERY OR CREMATORY: <u>Baltimore National Cem.</u>	LOCATION (City, town, or county) (State): <u>Balto., Md.</u>
DATE REC'D BY LOCAL REG. <u>JUN 23 58</u>	REGISTRAR'S SIGNATURE <u>Chas. Hacht</u>	24. FUNERAL DIRECTOR: <u>Chas. Hacht</u>	ADDRESS: <u>Balto., Md.</u>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6405

CERTIFICATE OF DEATH

06403

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>10</u> <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>726 Sixth Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Ardell</u> Middle <u>Allin</u> Last <u>Bentley, Jr.</u>				4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 4, 1958</u>	9. AGE (In years last birthday) <u>ys.</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>31</u>	IF UNDER 24 HRS. Hours <u>31</u> Mins. <u>51</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Annapolis Md</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Ardell Allin Bentley</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Irma Hopkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT <u>Mother</u> Address <u>726 Sixth Street, Annapolis, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Due to</u> (c) <u>Due to</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>4 June, 1958</u> , to <u>5 June, 1958</u> , that I last saw the deceased alive on <u>5 June, 1958</u> , and that death occurred at <u>6:50 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>121 Cathedral St. Annapolis June 5 - 58</u>			
PHYSICIAN'S NAME (Type) <u>STUART H. WALKER MD</u>							
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-6-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wheatcroft</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6406

CERTIFICATE OF DEATH

Reg. Dist. No.

06404

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Anne Arundel General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>William</u> Last <u>Pentley</u>				4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 4, 1958</u>	9. AGE (In years last birthday) yrs. <u>17</u>	IF UNDER 1 YEAR Months <u>17</u> Days <u>53</u>	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ardell Allin Pentley</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Irma Hopkins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT <u>Mother</u> Address <u>526 Sixth Street, Annapolis, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776x Prematurity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Due to</u> (c) <u>Due to</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4 June</u> , 19 <u>58</u> , to <u>5 June</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5 June</u> , 19 <u>58</u> , and that death occurred at <u>6:30</u> M from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>121 Cathedral St. Annapolis</u> DATE SIGNED <u>5 June 58</u>							
ACTUAL SIGNATURE <u>James W. Walker MD</u> M.D.				PHYSICIAN'S NAME (Type) <u>James W. Walker MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-6-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u> ADDRESS <u>Annapolis Md</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Albrecht</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6407

CERTIFICATE OF DEATH

06405

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>A. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. LENGTH OF STAY IN 1b <u>3 DA.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GEN. HOSPITAL</u>				e. STREET ADDRESS <u>RTE 1, Box 170-B</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EARL H. BOETTCHER</u>				4. DATE OF DEATH Month Day Year <u>6 10 1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/23/18</u>	9. AGE (In years last birthday) <u>39</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman-Assist Chief</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Naval Academy Fire Dept.</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Adolph Boettcher</u>				14. MOTHER'S MAIDEN NAME <u>Edith Mitchel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW II 219-01-1882</u>		17. INFORMANT Address <u>Mrs Frances E. Boettcher- Wife- same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE MYOCARDIAL INFARCTION</u> <u>4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY ATHEROSCLEROSIS</u> DUE TO (c) <u>UNKNOWN</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 HOURS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHOLELITHIASIS - + CHOLECYSTITIS -</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>FEB</u> , 19 <u>58</u> , to <u>6/10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/10/58</u> , 19 <u>58</u> , and that death occurred at <u>9:35 P.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>121 CATHEDRAL ST</u> <u>6/10/58</u>							
ACTUAL SIGNATURE <u>Richard N. Peeler</u>		M.D. <u>ANNAPOLIS, MD.</u>					
PHYSICIAN'S NAME (Type) <u>RICHARD N. PEELER</u>		<u>ANNAPOLIS, MD.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 14, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 16 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur Smith</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6408

CERTIFICATE OF DEATH

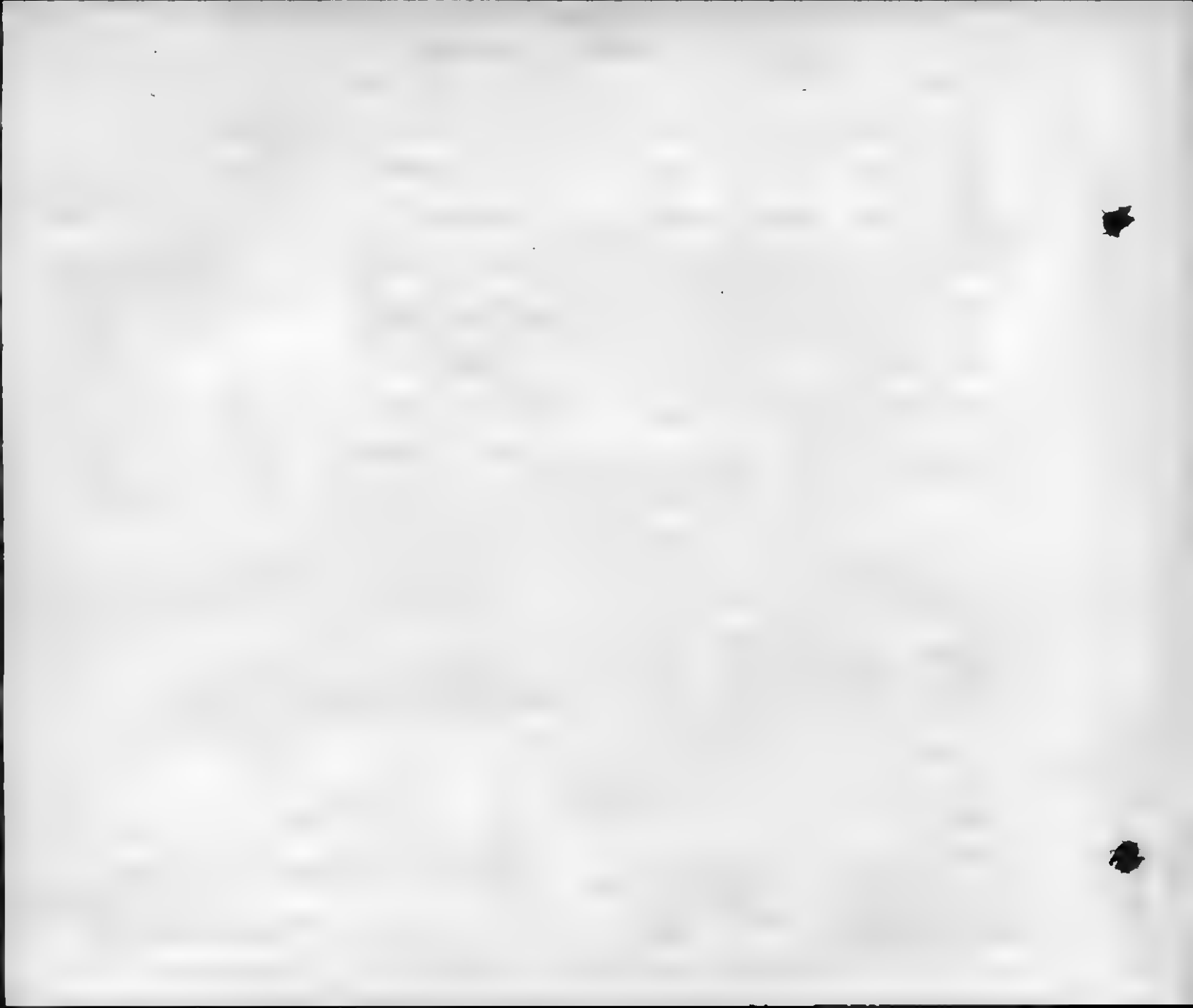
Reg. Dist. No. **66406**

1. PLACE OF DEATH a. COUNTY AA MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. General		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Henry Middle Buser Last Sr.		4. DATE OF DEATH Month 6 - Day 2 Year 1958	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr 27 - 1869	
9. AGE (In years last birthday) 89 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardner		10b. KIND OF BUSINESS OR INDUSTRY Gardner	
10c. BIRTHPLACE (State or foreign country) Switzerland		10d. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry Buser		14. MOTHER'S MAIDEN NAME Barbara Weiss	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Colise Buser		Address (2)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary Edema DUE TO 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of prostate DUE TO metastasis to bone (c) 1 y. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 hr.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-5-58 , 19 58 , to 6-2-58 , 19 58 , that I last saw the deceased alive on 6-2-58 , 19 58 , and that death occurred at 6:30 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 121 Cathedral St. G-3-58 DATE SIGNED Frank M. Shipley ACTUAL SIGNATURE Frank M. Shipley M.D. Annapolis, Md. PHYSICIAN'S NAME (Type) Frank M. Shipley			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-4-58	
22c. NAME OF CEMETERY OR CREMATORY St. Charles		22d. LOCATION (City, town, or county) (State) Annapolis Md	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons		24a. REC'D BY REGISTRAR DATE JUN 5 '58	
24b. REGISTRAR'S SIGNATURE Alberich			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06407

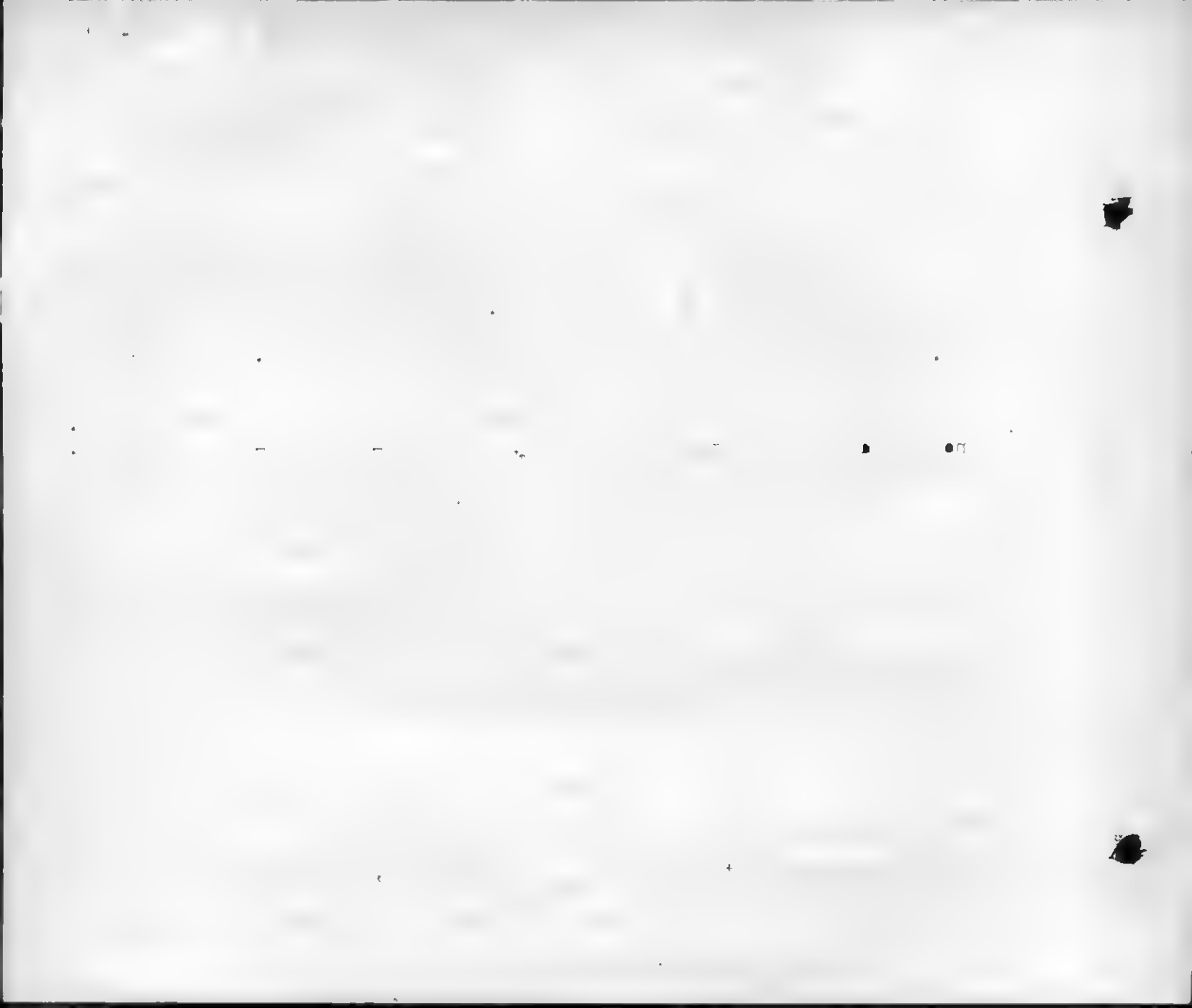
6429

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAMBRILLS c. LENGTH OF STAY IN 1b GAMBRILLS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAMBRILLS d. STREET ADDRESS GAMBRILLS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM F BUTLER		4. DATE OF DEATH Month Day Year JUNE 11 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 20, 1876
9. AGE (In years last birthday) yrs 82		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Prince George Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. James Leddy- Daughter-		Address Southgate Ave. Annapolis, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 1/2 yrs 10 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1946 to June 11 1958 , that I last saw the deceased alive on June 6 1958 , and that death occurred at 7:54 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Edward Skerritt M.D. 6-13-58			
ACTUAL SIGNATURE Edward Skerritt		M.D. 6-13-58	
PHYSICIAN'S NAME (Type) Edward Skerritt MD		Gambrills, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 14, 58	22c. NAME OF CEMETERY OR CREMATORY Our Lady of the Fields	22d. LOCATION (City, town, or county) (State) Millersville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME		ADDRESS Annapolis, Maryland	
24a. REC'D BY REGISTRAR JUN 16 '58		24b. REGISTRAR'S SIGNATURE J. J. Maden	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6430

CERTIFICATE OF DEATH

06408

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Unknown			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN TB 22y 9m 23d			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Unknown				d. STREET ADDRESS Unknown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Shirley				4. DATE OF DEATH Month 6 Day 3 Year 19 58			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1895?	
9. AGE (In years last birthday) 63?		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY —			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Lillian Campbell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Hospital Records			
17. ADDRESS Hospital Records							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia 1621 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchogenic Carcinoma of the left lung with metastases DUE TO (c) —							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Paranoid Schizophrenic							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. —				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	
20f. (City or town) —				20g. (County) —		20h. (State) —	
21. I certify that I attended the deceased from July 56 to June 3 19 58 , that I last saw the deceased alive on June 3, 19 58 and that death occurred at 1:40 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Lionel McHenry Mapp, M.D.				DATE SIGNED 6-3-58			
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.				ADDRESS (Street, city or town, state) Crownsville State Hospital, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or county) (State) Crownsville, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Charles Ward Mapp				24a. REC'D BY REGISTRAR DATE JUN 11 '58			
24b. REGISTRAR'S SIGNATURE —				24c. REGISTRAR'S SIGNATURE —			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

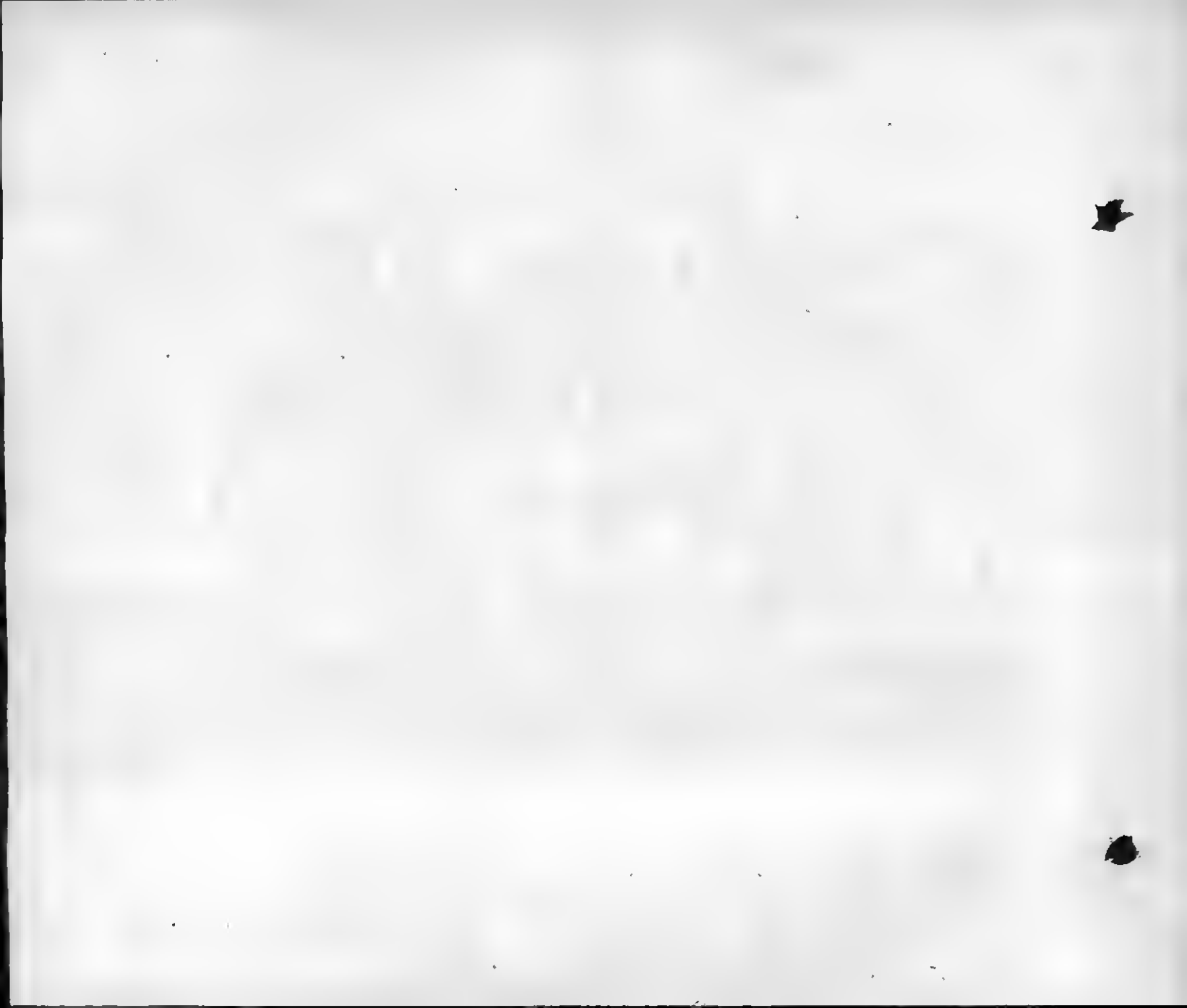
6431

66409

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY in 1b <u>15 months</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>601 Tranton Rd.</u>		e. STREET ADDRESS <u>Same</u>	
3. NAME OF DECEASED (Type or print) <u>George Joseph Carroll</u>		4. DATE OF DEATH Month <u>June</u> Day <u>21st</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/30/99</u>
9. AGE (in years last birthday) <u>59</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Boiler Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>?</u>		16. SOCIAL SECURITY NO <u>?</u>	
17. INFORMANT <u>Elleston Carroll (son.)</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>241X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Asthma</u> (c) <u> </u> (a), stating the underlying cause last. DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>		DATE SIGNED <u>June 22 1958</u>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/25/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kirkley</u>		24a. REC'D BY REGISTRAR <u> </u>	
ADDRESS <u>Hopping and Kirkley, Glen Burnie, Md.</u>		DATE <u>JUN 25 '58</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6432

CERTIFICATE OF DEATH

Reg. Dist. **66410**

1. PLACE OF DEATH a. COUNTY A.A. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY A.A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riviera Beach Pasadena				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riviera Beach Pasadena Md			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION Box 209 Dale Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WALTER Walton Chaney				4. DATE OF DEATH June 25 1958			
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18 1875	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months — Days — Hours — Min. —		IF UNDER 24 HRS Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARM		11. BIRTHPLACE (State or foreign country) USA - A.A. Co.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Richard Chaney				14. MOTHER'S MAIDEN NAME Mary Elizabeth Chaney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 215-23-5418A		17. INFORMANT Katherine Chaney Address 1205 S. 1st St. Baltimore, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Infection 420.0 DUE TO Cardiac Decompensation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction (c) Arteriosclerotic Heart Disease						INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schistosity						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour — o. m. — p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 6/21 1958 to 6/27 1958 that I last saw the deceased alive on 6/27 1958 , and that death occurred at 12:44 M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 715 Cottage Rd. Baltimore, Md.				DATE SIGNED 6/28/58			
ACTUAL SIGNATURE R.W. Prichard				M.D. —			
PHYSICIAN'S NAME (Type) R.W. PRICHARD							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 7/1/58		22c. NAME OF CEMETERY OR CREMATORY MEADOW RIDGE		22d. LOCATION (City, town, or county) (State) HOWARD COUNTY, MD	
23. FUNERAL DIRECTOR'S SIGNATURE Hopling & BIRNEY, Glen BURNIE				ADDRESS —		24a. REC'D BY REGISTRAR —	
24b. REGISTRAR'S SIGNATURE —				DATE JUL 9 '58			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6433 CERTIFICATE OF DEATH

Reg. Dist. No.

66411

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>		c. LENGTH OF STAY IN 1b <u>5 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>304 Hilltop Rd.</u>			d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph Ernest Clarke</u>			4. DATE OF DEATH Month Day Year <u>June 13 1958</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 20 1888</u>		9. AGE (in years last birthday) <u>69</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant - Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CPA</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			13. FATHER'S NAME <u>J. Beauregard Clarke</u>		
14. MOTHER'S MAIDEN NAME <u>Ella Scott</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>217-12-9784</u>			17. INFORMANT Address <u>Angela Clarke</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardio-Vascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>8-9 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>1950 to 6/13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 13</u> , 19 <u>58</u> , and that death occurred at <u>9:45 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Chas. L. Ball Jr.</u> M.D. <u>Linthicum</u>			ADDRESS (Street, city or town, state) <u>6/13/58</u>		
PHYSICIAN'S NAME (Type) _____					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/19/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Lawrence Cem.</u>	
22d. LOCATION (City, town, or county) <u>Jessup, Md.</u>		(State) <u>Md.</u>		24a. REC'D BY REGISTRAR DATE <u>16 '58</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WM. J. TICKNER & SONS</u>			24b. REGISTRAR'S SIGNATURE <u>6/16/58</u>		
ADDRESS <u>Balto. Md.</u>					



6434 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

COUNTY

Anne Arundel

MARYLAND

CITY (If outside corporate limits, write OR and give nearest town)

TOWN Isle Burnie, Md.

LENGTH OF STAY (in this place)

14 mo

HOSPITAL OR INSTITUTION OR STREET ADDRESS

2 Queen Anne Rd

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Maryland

COUNTY

Baltimore

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN 30 E. West St

STREET ADDRESS

(If rural give location)
Baltimore, Md.

3. NAME OF DECEASED:

(First)

MARY

(Middle)

SUSAN

(Last)

CLINTON

(Type or Print)

4. DATE

(Month)

(Day)

(Year)

OF DEATH:

June

3

19 58

5. SEX:

F

6. COLOR OR RACE:

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

married

8. DATE OF BIRTH:

20 May 1889

9. AGE last birthday:

69 yrs.

If UNDER 1 YEAR If UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):

Hawf.

10b. KIND OF BUSINESS OR INDUSTRY:

Home

11. BIRTHPLACE (State or foreign country):

Harford County, Md.

12. CITIZEN OF WHAT COUNTRY?

Yes

13. FATHER'S NAME:

Charles R. MARRELL (dec)

14. MOTHER'S MAIDEN NAME:

Eugenie Schultz (dec)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

no

16. SOCIAL SECURITY No.:

none

17. INFORMANT & ADDRESS:

Husb. Samuel R. Clinton

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

5702.

Immediate cause

(a)

acute nephritis

DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

Cerebral Vascular Accident

DUE TO

(c)

Hypertension

Interval Between Onset And Death

2 weeks

2 yrs

10 yrs

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

none

20. AUTOPSY ?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

None

PLACE (Home, farm, factory, street, or office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

June 3 1958 12:45 AM

INJURY OCCURRED

While at Work ☒ Not While at Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from 2 June, 1958, to 3 June, 1958, that I last saw the deceased

alive on

SIGNATURE

2 June 1958, and that death occurred at 12:45 AM, from the causes and on the date stated above.

(Degree or title)

ADDRESS

DATE SIGNED

H-F Manugeth M.D.

901 Edgerly Rd, Glen Burnie, Md

3 June 1958

23. BURIAL, CREMATION, REMOVAL

DATE THEREOF

6-6-58

NAME OF CEMETERY OR CREMATORY

Cedar Hill Cemetery

LOCATION (City, town, or county)

5829 Ritchie Highway

(State)

DATE REC'D BY LOCAL REGISTRAR

JUN 4 '58

REGISTRAR'S SIGNATURE

W. H. Schuch

24. FUNERAL DIRECTOR

ADDRESS

William Cook, Inc., 1217 St. Paul Street

Note - Patient has been under medical care by five other doctors.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



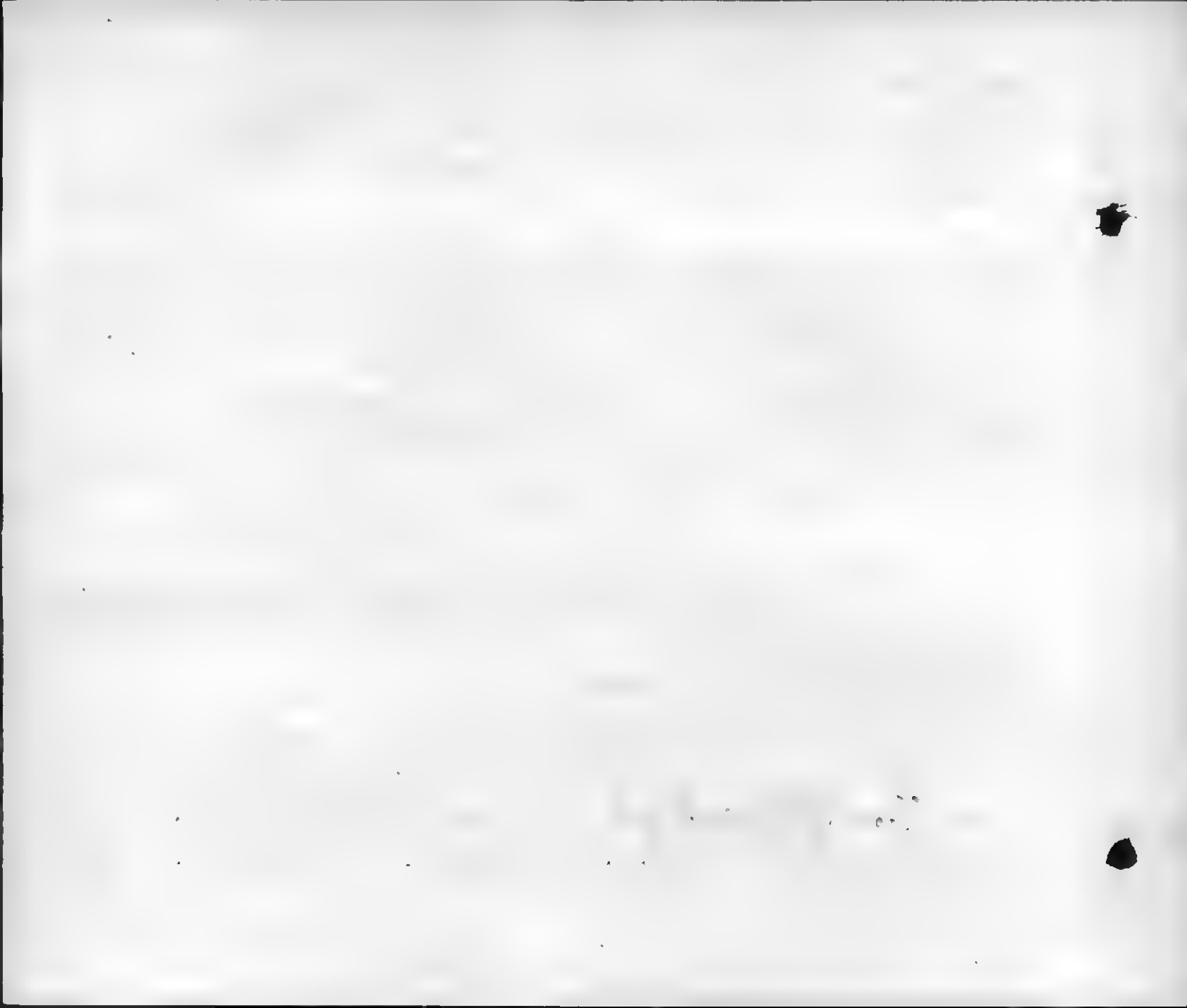
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6435

CERTIFICATE OF DEATH

Reg. Dist. No. 06413

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 1 day			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First James Middle Robert Last Cole				4. DATE OF DEATH Month 6 Day 1 Year 19 58			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1873	
9. AGE (In years last birthday) 85 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. 219 01 3547		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypostatic Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebralvascular Accident (probably thrombosis) DUE TO (c) Hypertensive and Arteriosclerotic Cardiovascular Disease.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility and mal-nutrition.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from 5/30/19 58 to 6/1/19 58 , that I last saw the deceased alive on 6/1/19 58 and that death occurred at 9:45 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 6/1/58 ACTUAL SIGNATURE Lionel McHenry Mapp, M. D. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D. Crownsville State Hospital, Md. 6/1/58							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6-5-58		22c. NAME OF CEMETERY OR CREMATORY St Mary's		22d. LOCATION (City, town, or county) (State) Bryantown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hunt Funeral Home ADDRESS Waldorf, Md.				24a. REC'D BY REGISTRAR DATE JUN 9 '58		24b. REGISTRAR'S SIGNATURE W. H. Leach	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06414

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A. A. General</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution, residence before admission) a. STATE <u>Cal.</u> b. COUNTY <u>Los Angeles</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monrovia</u> d. STREET ADDRESS <u>2503 Graydon St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ferdinand Herman Congelman</u> First Middle Last 5 SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>4-2-1897</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>61</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Mechanic</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Auto Mechanic</u> 11. BIRTHPLACE (State or foreign country) <u>St Louis Mo.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>		13. FATHER'S NAME <u>Fred Congelman</u> 14. MOTHER'S MAIDEN NAME <u>Anna Kern</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service) <u>-</u> 16. SOCIAL SECURITY NO. <u>-</u> 17. INFORMANT <u>Lillie M. Congelman</u> Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Disease</u> 434.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>	
ACTUAL SIGNATURE <u>E. Linhardt</u> EXAMINER'S NAME (Type) <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>6-7-58</u>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>6-7-58</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Forest Lawn</u> 22d. LOCATION (City, town, or county) <u>Glendale</u> (State) <u>Cal.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u> ADDRESS <u>Annapolis Md</u> 24a. REC'D BY REGISTRAR <u>JUN 9</u> DATE 24b. REGISTRAR'S SIGNATURE <u>W. J. Smith</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

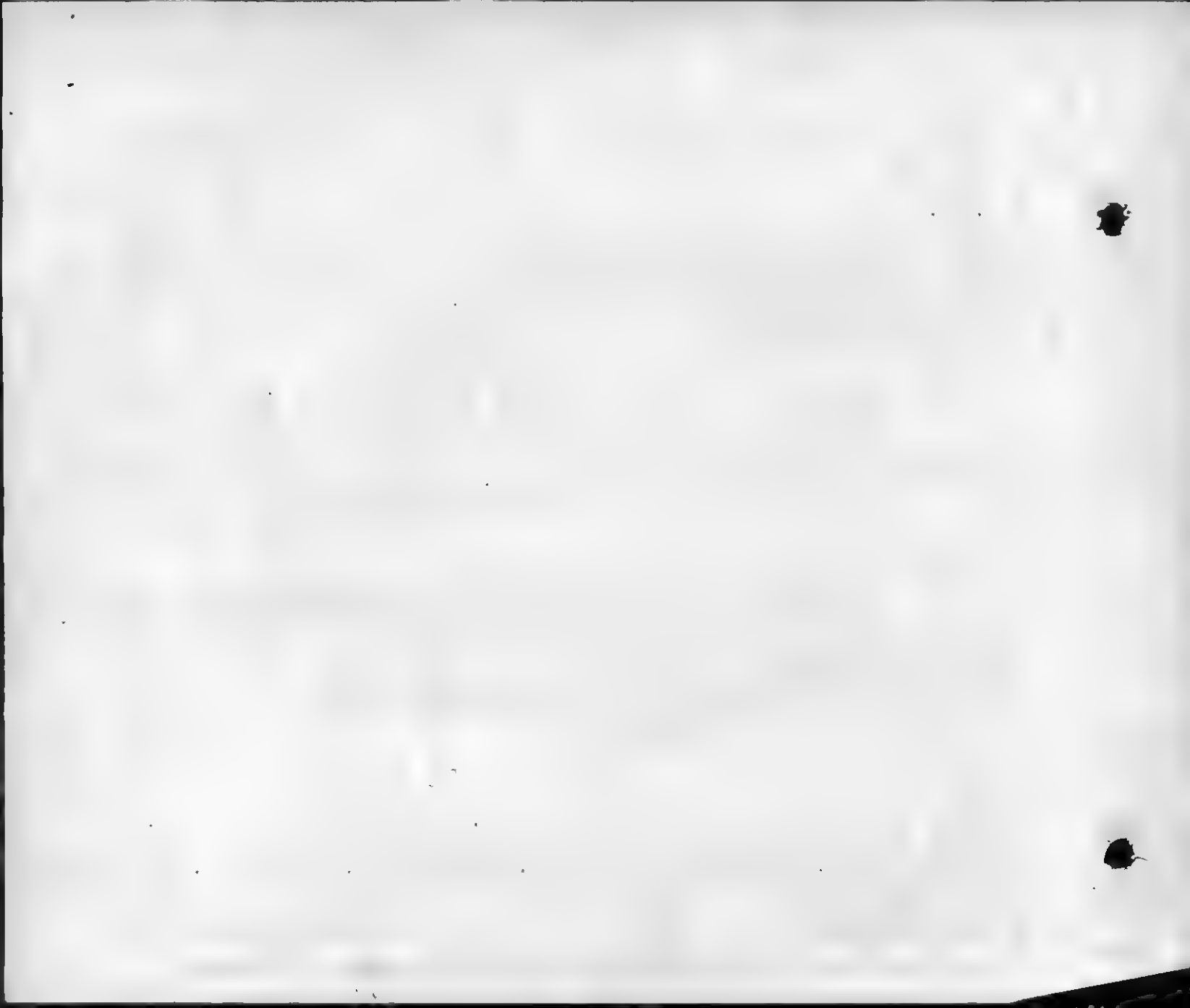
6436

CERTIFICATE OF DEATH

06415

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>H. H.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie Fort Meade</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. A. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>RAYMOND A DEARDORF</u>				4. DATE OF DEATH Month Day Year <u>June 6 5 19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 6, 1898</u>	
9. AGE (In years last birthday) yrs. <u>59</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Medical Analyst</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Sylvester Deardorf</u>				14. MOTHER'S MAIDEN NAME <u>Margarett (last name unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u> <u>Vet WW 1 & 2</u>		16. SOCIAL SECURITY NO <u>Unknown</u>		17. INFORMANT <u>Opal Deardorf</u> Address <u>20 Elm St, Country Club Estates</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion (suspected)</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Lead on Arrival</u> to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>935 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John R. Robertson</u>				M.D. <u>U. S. ARMY HOSPITAL, Ft Meade, Md</u> DATE SIGNED <u>6 Jun 58</u>			
PHYSICIAN'S NAME (Type) <u>JOHN R. ROBERTSON, CAPT. MD, US. ARMY HOSPITAL, FT GEORGE G. MEADE, MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Initial</u>		22b. DATE THEREOF <u>June 10, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cem - Fort Myer, Va.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. J. Singleton</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>19 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. J. Singleton</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6410

CERTIFICATE OF DEATH

06416

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>aa</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>md</i> b. COUNTY <i>aa</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>St. General</i>				d. STREET ADDRESS <i>1000 Bay Ridge Ave</i>			
3. NAME OF DECEASED (Type or print) <i>Oslando H. Duwall</i>				4. DATE OF DEATH <i>6-19-1958</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-11-1875</i>	9. AGE (In years last birthday) <i>82</i> yrs	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Farmer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Dairy Farming</i>		11. BIRTHPLACE (State or foreign country) <i>A. A. Co. Md.</i>	
13. FATHER'S NAME <i>Richard Duwall</i>				14. MOTHER'S MAIDEN NAME <i>Laura Hancock</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Mrs. W. Clyde Mills</i> Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>(c) Arteriosclerotic cardiovascular disease</i>							INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>Jan</i> 19 <i>50</i> , to <i>6-19</i> 19 <i>58</i> , that I last saw the deceased alive on <i>6-18</i> 19 <i>58</i> , and that death occurred at <i>11:30</i> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>S. Borssuck</i> M.D.				ADDRESS (Street, city or town, state) <i>Annapolis Md</i> DATE SIGNED <i>6/19/58</i>			
PHYSICIAN'S NAME (Type) <i>S. Borssuck</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-22-58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St. Margarets</i>		22d. LOCATION (City, town, or county) (State) <i>St. Margarets 2946 Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i> ADDRESS <i>Annapolis Md.</i>				24a. REC'D BY REGISTRAR <i>JUN 23 '58</i>		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



6437

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft George G. Meade		c. LENGTH OF STAY IN 1b 20 Minutes	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Army Hospital		d. STREET ADDRESS Box #2 Jessup, Md	
3. NAME OF DECEASED (Type or print) First TINA Middle MARIE Last ESTES		4. DATE OF DEATH Month JUNE Day 5 Year 1958	
5. SEX Female	6. COLOR OR RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 5, 1958
9. AGE (In years last birthday) yrs. 20		IF UNDER 1 YEAR: Months 20 Days 20 Hours 20 Min. 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME VON RAY ESTES		14. MOTHER'S MAIDEN NAME BONNIE KATE HOWELL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT Father Von Estes		Address Box 2 Jessup, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Premature, immaturity, DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH 20 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5 June, 1958 , to 5 June, 1958 , that I last saw the deceased alive on 5 June, 1958 , and that death occurred at 2:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Neil S. Stewart		M.D. U. S. ARMY HOSP., FT MEADE, MD 5 June 58	
PRINTED NAME (Type) NEIL S. STEWART, CAPT. MC, US ARMY HOSPITAL, FT MEADE, MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) 6/9/58		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Bethesda National		22d. LOCATION (City, town, or county) (State) Bethesda, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Carl B. Wolcott		24a. REC'D BY REGISTRAR 6/9/58 24b. REGISTRAR'S SIGNATURE W. L. ...	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 must be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7



2. 1.

2. 1.

3. 1.

0.1

2



BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6438

CERTIFICATE OF DEATH

06418

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY AA MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ADA Middle MARY Last GARBER		4. DATE OF DEATH Month 6 Day 15 Year 1958	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-14-1893
9. AGE (In years lost birthday) 65 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 1 Days 15 Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME JOHN HOOK		14. MOTHER'S MAIDEN NAME MARY HODGES	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —	
17. INFORMANT RAYMOND G. GARBER Address 2816 E. Young Street			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) BREAST CA WITH METASTASES DUE TO IN LUNGS AND BONES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — DUE TO (c) —			INTERVAL BETWEEN ONSET AND DEATH 13 mo
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) —			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) —	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6-4 , 19 58 to 6-14 , 19 58 , that I last saw the deceased alive on 6-14-58 , and that death occurred at 12:50 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Otto Vogel MD M.D.		ADDRESS (Street, city or town, state) Box 481-A DATE SIGNED 6-15-58	
PHYSICIAN'S NAME (Type) OTTO VOGEL, M.D.		PASADENA, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6-17-58	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) Baltimore Md
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higginbotham ADDRESS Ellicott City, Md		24a. REC'D BY REGISTRAR JUN 17 1958 DATE 24b. REGISTRAR'S SIGNATURE W. H. Church	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6439

CERTIFICATE OF DEATH

06419

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Box 513</u>	
3. NAME OF DECEASED (Type or print) First <u>JACOB</u> Middle <u>Geller</u> Last <u>Geller</u>		4. DATE OF DEATH Month <u>0</u> Day <u>11</u> Year <u>1900</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 11, 1903</u>
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR: Months <u>0</u> Days <u>11</u> Hours <u>00</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>machinery</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Geller</u>		14. MOTHER'S MAIDEN NAME <u>Christina</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Henry Geller Ste 2 Box 503, Severna Park</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>infection of the heart</u> DUE TO (b) <u>Coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>OV</u> , 19 <u>00</u> , to <u>June 10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 10</u> , 19 <u>58</u> , and that death occurred on <u>June 11</u> , 19 <u>58</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Andrew Szabo, M.D.</u>		DATE SIGNED <u>June 11, 1958</u>	
PHYSICIAN'S NAME (Type) <u>Andrew Szabo, M.D.</u>		<u>Len Arnice, Jr. and</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jun 10, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery, Md. Pk.</u>	22d. LOCATION (City, town, or county) (State) <u>Howard Co., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>PK Singleton</u>		24a. REC'D BY REGISTRAR <u>JUN 9 '58</u>	
ADDRESS <u>Glen Burnie, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6440

CERTIFICATE OF DEATH

06420

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE W. VIRGINIA b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				c. LENGTH OF STAY IN 1b 2 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Leroy Drive				d. STREET ADDRESS 528 1/2 Walnut St			
3. NAME OF DECEASED (Type or print) First Samuel Middle - Last Corrad				4. DATE OF DEATH Month JUNE Day 29 Year 1958			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 21 - 1875	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY (Self) Retired		11. BIRTHPLACE (State or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) NO		16. SOCIAL SECURITY NO. -		17. INFORMANT Family		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH NONE	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. p. m. Month. Day. Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 6-22 , 19 58 , to 6-29 , 19 58 , that I last saw the deceased alive on 6-22 , 19 58 , and that death occurred at 1:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 201 B & A BLVD DATE SIGNED 6-29-58							
ACTUAL SIGNATURE Leon C. Perry				M.D. 201 B & A BLVD			
PHYSICIAN'S NAME (Type) LEON C. PERRY, M.D.				GLEN BURNIE, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-3-58		22c. NAME OF CEMETERY OR CREMATORY Holy Cross Cem.		22d. LOCATION (City, town, or county) (State) Charlestown, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Alfred Smith				ADDRESS		24a. REC'D BY REGISTRAR DATE JUL 1 '58	
				24b. REGISTRAR'S SIGNATURE Alfred Smith			



6411

CERTIFICATE OF DEATH

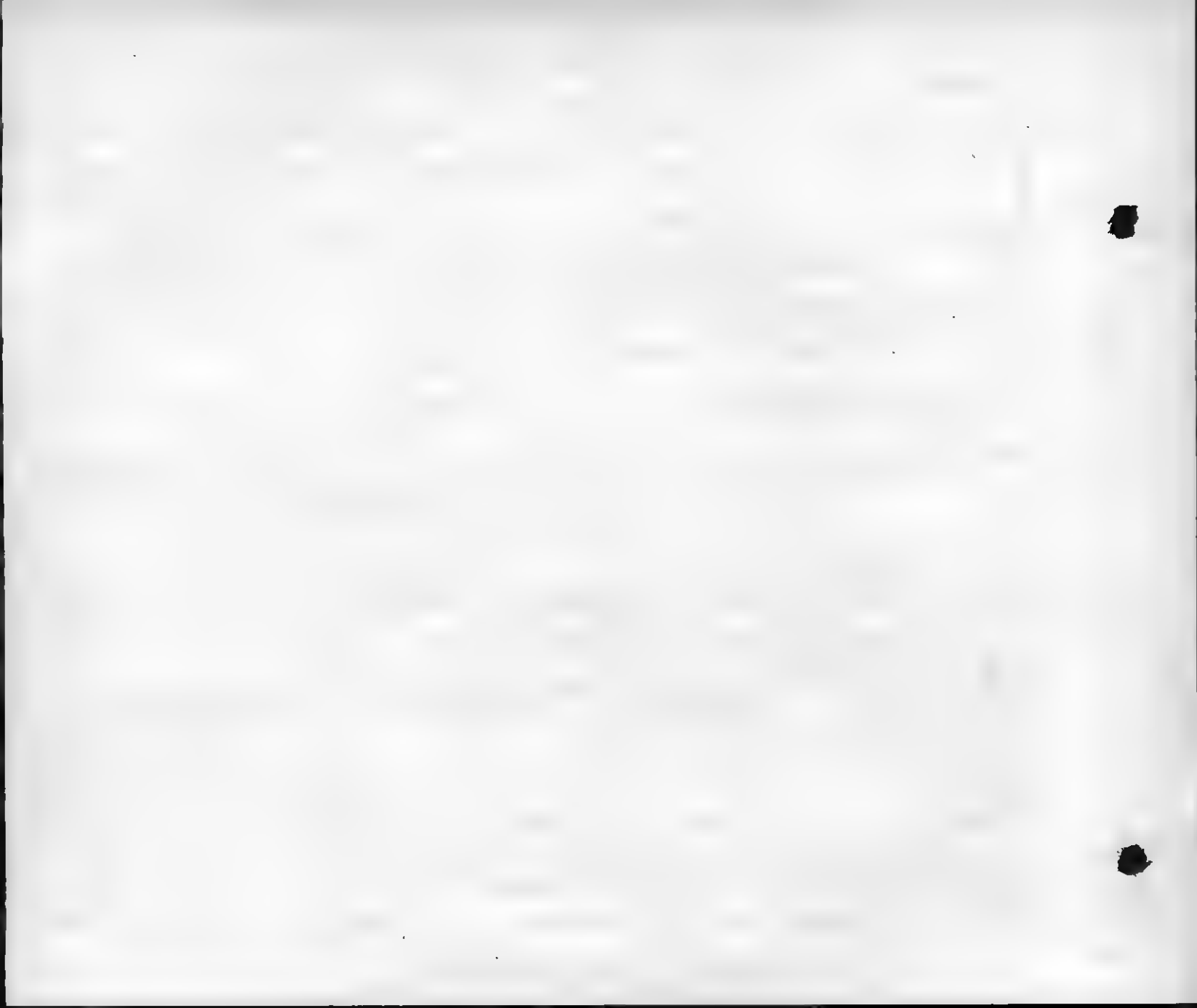
06421

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>md</u> b. COUNTY <u>aa</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>St. Agnes General Hosp</u>		d. STREET ADDRESS <u>4 Arden Place</u>	
3. NAME OF DECEASED (Type or print) First <u>Sara</u> Middle <u>Sutherland</u> Last <u>Green</u>		4. DATE OF DEATH Month <u>6-</u> Day <u>13-</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-14-1886</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Dr David Cameron Sutherland</u>		14. MOTHER'S MAIDEN NAME <u>Kate Scott Armicost</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>yes</u> (If yes, give year or date of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>MISS INDIA SUTHERLAND</u>	
17. INFORMANT <u>#2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Necrotizing pancreatitis</u> <u>587.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/17</u> , 19 <u>58</u> , to <u>6/13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/12</u> , 19 <u>58</u> , and that death occurred on <u>6/13</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard K. Peeler</u> M.D.		DATE SIGNED <u>6/14/58</u>	
PHYSICIAN'S NAME (Type) <u>RICHARD K. PEELER</u>		<u>ANNAPOLIS, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-16-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Ann's</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Layton</u>		24a. REC'D BY REGISTRAR <u>JUN 16 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. E. Green</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD

6441

CERTIFICATE OF DEATH

Reg. Dist. No. 06422

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Chesapeake</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crofton Burnie</i>		c. LENGTH OF STAY IN 1b <i>6/13/58</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Maria Manor Nursing Home</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Balto.</i>	
3. NAME OF DECEASED (Type or print) <i>Nancy</i> First <i>—</i> Middle <i>—</i> Last <i>Hallette</i>		4. DATE OF DEATH Month <i>6</i> Day <i>20</i> Year <i>1958</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1893</i> 9. AGE (In years last birthday) <i>64</i> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Cape Charles Va.</i>	
11. BIRTHPLACE (State or foreign country) <i>Cape Charles Va.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>George Thomas</i>		14. MOTHER'S MAIDEN NAME <i>Belle Robinson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Tamer Cheek</i> Address <i>2724 E. Chase St.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Subarachnoid Hemorrhage.</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Cardio Vascular Disease</i> (c) <i>Chronic Atherosclerotic Cardio Vascular Disease</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Rght + Hemiplegia</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>—</i> p. m. <i>—</i> 19 <i>58</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>6-13</i> , 19 <i>58</i> , to <i>6-20</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>6-13</i> , 19 <i>58</i> , and that death occurred at <i>8:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Febus Greiner</i> M.D. <i>10 Gell St. Crofton Md.</i>		DATE SIGNED <i>6/20/58</i>	
PHYSICIAN'S NAME (Type) <i>Febus Greiner</i>			
22a. BURIAL, CREMATION, or REMOVAL (Specify)	22b. DATE THEREOF <i>6/24/1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cape Charles Va.</i>	22d. LOCATION (City, town or county) (State) <i>Cape Charles Va.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mrs. Kate R. Williams</i> ADDRESS <i>Schroeder St.</i>		24a. REC'D BY REGISTRAR <i>JUN 23 '58</i>	24b. REGISTRAR'S SIGNATURE <i>—</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

64123 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

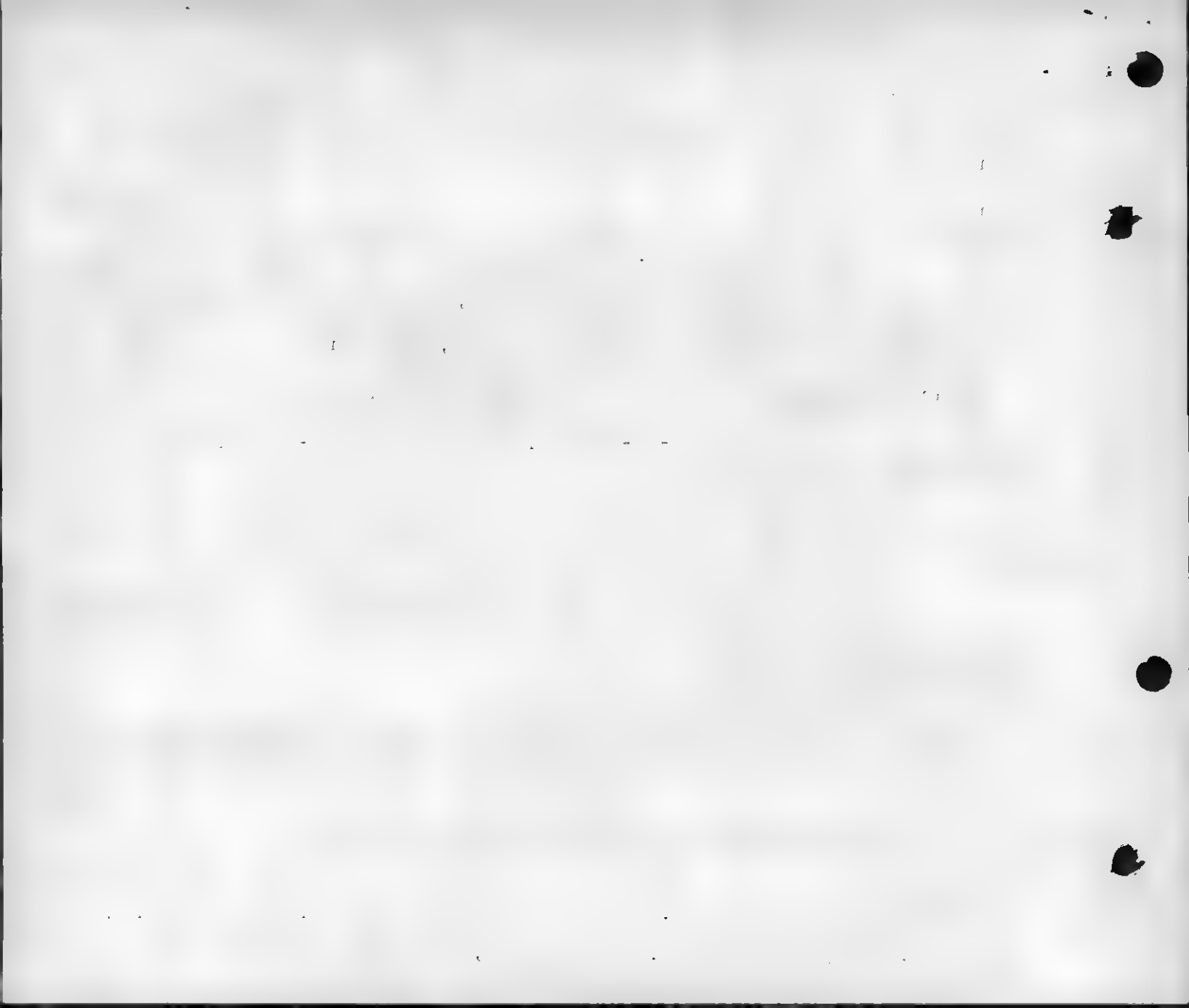
06423

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>AA Co.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>AnneArundel Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MARY</u> b. COUNTY <u>AA Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>6113 Willmont</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Chesler</u> First <u>A.</u> Middle <u>Hammett</u> Last				4. DATE OF DEATH Month <u>6</u> Day <u>20</u> Year <u>1958</u>											
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 15, 1889</u>		9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>5</u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>				11. BIRTHPLACE (State or foreign country) <u>Ridge, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Spencer Hammett</u>						14. MOTHER'S MAIDEN NAME <u>Kate Johnson</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>578-07-1518</u>				17. INFORMANT <u>J. William Hammett-Same Item #2</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>												INTERVIEW BETWEEN ONSET AND DEATH <u>Autopsy</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month, Day, Year <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>															
ACTUAL SIGNATURE <u>[Signature]</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>6/20/58</u>							
EXAMINER'S NAME (Type) <u>E. L. Howard</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>6/20/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Washington D. C.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-7557 Wis. Ave. Bethesda, Md</u>												24a. REC'D BY REGISTRAR DATE <u>JUN 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please file this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



6442

CERTIFICATE OF DEATH

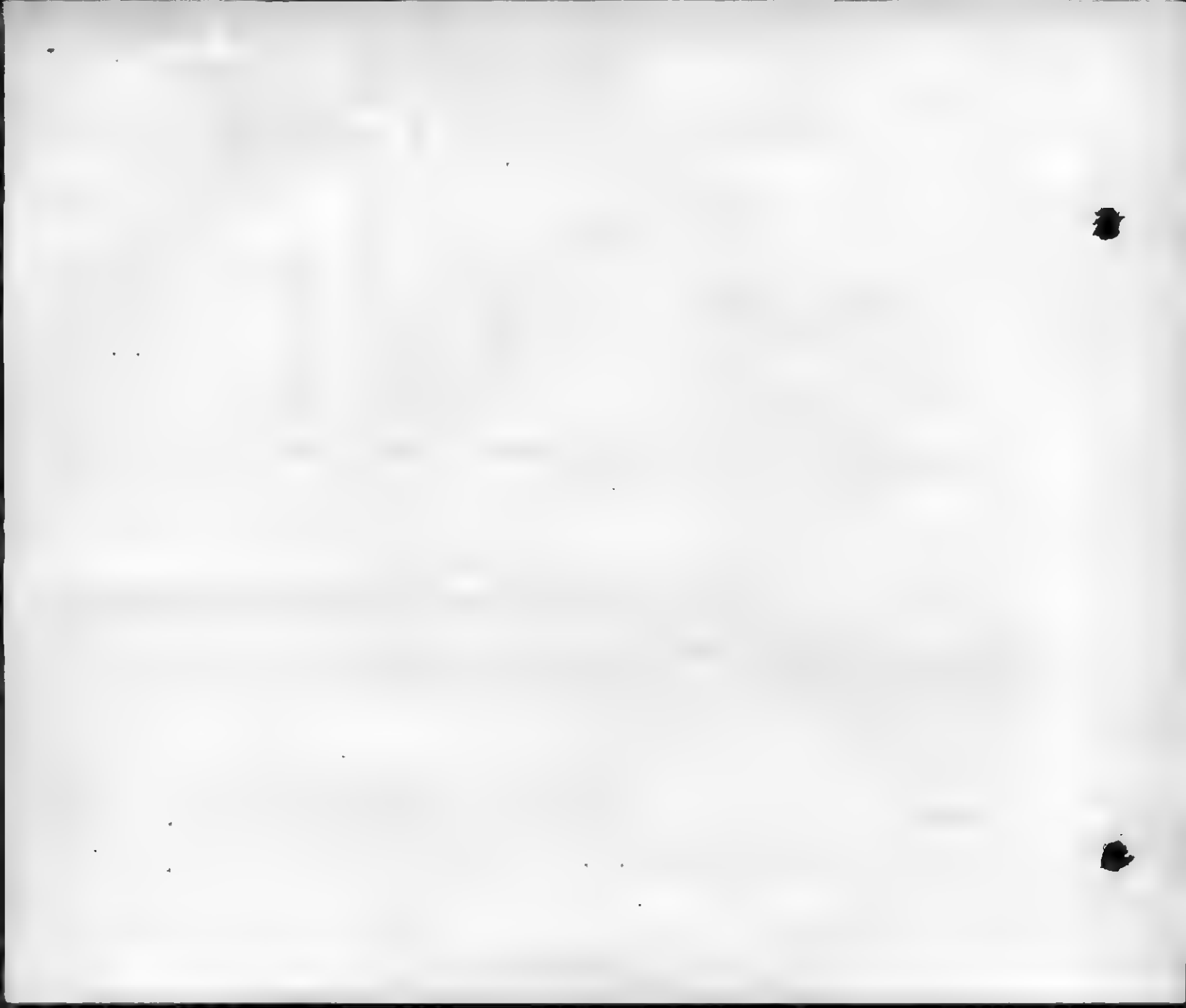
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel County MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 12y 4m 27d			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Clara Middle Harris Last Harris				4. DATE OF DEATH Month 6 Day 23 Year 1958			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1881	
9. AGE (In years last birthday) yrs. 77		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jesse Jones (Deceased)				14. MOTHER'S MAIDEN NAME Jane Shield (Deceased)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. Hospital Records		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation 435.. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ACVD DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile Deterioration							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from January 6, 1955, to June 23, 1958 , that I last saw the deceased alive on June 23, 1958 , and that death occurred at 2:30 P.M. from the causes and on the date stated above							
ACTUAL SIGNATURE <i>Hildegard Reissmann</i>				ADDRESS (Street, city or town, state) Crownsville State Hospital, Md.			
PHYSICIAN'S NAME (Type) Hildegard Reissmann, M. D.				DATE SIGNED 6/24/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6-25-58		22c. NAME OF CEMETERY OR CREMATORY Calto. Md.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, Jr. - Annapolis, Md.</i>				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6443

CERTIFICATE OF DEATH

06425

Reg. Dist. No. _____

1. PLACE OF DEATH a. COUNTY Anne Arundel		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Georgia b. COUNTY ---	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft Geo G Meade Md		c. LENGTH OF STAY IN 1b Just arriving PCS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U S Army Hospital		d. STREET ADDRESS Avondale Estates Not given	
3. NAME OF DECEASED (Type or print) John		4. DATE OF DEATH Month June Day 22 Year 19 58	
5. SEX Male		6. COLOR OR RACE Caucasian	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 17 March 1908	
9. AGE (In years last birthday) yrs 50		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY U S Army	
11. BIRTHPLACE (State or foreign country) AVONDALE ESTATES, GEORGIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME deceased		14. MOTHER'S MAIDEN NAME Dorothy A Harrison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes		16. SOCIAL SECURITY NO. 259-07-7687	
17. INFORMANT Sgt Withey, Post Personnel Rcds, Ft Meade, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction acute 4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 22 June , 19 58 , to 22 June , 19 58 , that I last saw the deceased alive on 22 June , 19 58 , and that death occurred at 4:45 PM , from the causes and on the date stated above. ACTUAL SIGNATURE George B. Hagan, Capt MC ADDRESS (Street, city or town, state) Ft Meade, Md. DATE SIGNED 22 June 58 PHYSICIAN'S NAME (Type) GEORGE B FAGAN Capt MC			
22a. REMOVAL (Specify) Removal		22b. DATE THEREOF 6/25/58	
22c. NAME OF CEMETERY OR CREMATORY A.S. Turner Morticians		22d. LOCATION (City, town, or county) (State) Decatur Georgia	
23. FUNERAL DIRECTOR'S SIGNATURE Earl B. Wolverton		24a. REC'D BY REGISTRAR DATE JUL 1 '58	
ADDRESS Funeral Home, Inc.		24b. REGISTRAR'S SIGNATURE W. J. ...	

6306 - Belair Rd - Baltimore 6, Md

I, the undersigned, received the body of SFC John W Harrison, RA 3/ 4/1 676 from the U S Army Hospital, Fort George G Meade, Md at 2030 hours, 24 June 1958 in good condition.

Earl B Wolverton Funeral Home Inc.,
6306 Belair Rd., Baltimore, Md

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, marking the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06426

Item 20 Film 240

6413

Item 6 Film G230 6-11-58 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A.A.</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i> c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>A.A.</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Severna Park</i> d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>T.</i> Last <i>Hart</i>		4. DATE OF DEATH Month <i>6</i> Day <i>1</i> Year <i>1958</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug-18-1928</i>	9. AGE (In years last birthday) <i>29</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Meat Cutter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Meat Cutter</i>		11. BIRTHPLACE (State or foreign country) <i>Va.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Thomas Hart</i>		14. MOTHER'S MAIDEN NAME <i>Grace F. Nicholson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i> (If yes, give year or dates of service) <i>WW II</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Rose Marie Hart</i> Address <i>(2)</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Crushing injury to chest</i> 823X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Car ran off road down bank</i>			
20c. TIME OF INJURY Hour <i>19</i> o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Route 178</i>	
20f. (City or town) <i>Islehart</i>		20g. (County) <i>AA</i>		20h. (State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>John M. Taylor</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>John M. Taylor</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-4-58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Washington National</i>	
22d. LOCATION (City, town, or county) <i>Washington</i>		22e. (State) <i>Va.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i>		ADDRESS <i>Annapolis</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 5 '58</i>	
				24b. REGISTRAR'S SIGNATURE <i>Edw. - edison</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 6-7 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6414

CERTIFICATE OF DEATH

06427

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>1111 Military Hill</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Johnson</u>		4. DATE OF DEATH Month Day Year <u>June 11 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 10, 1958</u>
9. AGE (In years last birthday) yrs		10. AGE UNDER 1 YEAR IE UNDER 24 HRS Months Days Hours Min <u>11 11 11 11</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Elizabeth Cook</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mother</u>		Address <u>It. 3, Box 271, Annapolis, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>under development</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-10-58</u> , 19 <u>58</u> , to <u>6-11-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6-11-58</u> , 19 <u>58</u> , and that death occurred at <u>4 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>AT Allen</u>		DATE SIGNED <u>6-14-58</u>	
PHYSICIAN'S NAME (Type) <u>A T ALLEY</u>		ADDRESS (Street, city or town, state) <u>Annapolis, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>6-15-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Pine Hill</u>		22d. LOCATION (City, town or county) (State) <u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Jones</u>		ADDRESS <u>1111 Military Hill</u>	
24a. REC'D BY REGISTRAR <u>JUN 18 58</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	



6415

CERTIFICATE OF DEATH

06429

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Gen Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELLA</u> First <u>ISABEL</u> Middle <u>LANGLEY</u> Last		4. DATE OF DEATH <u>June</u> Month <u>7</u> Day <u>1958</u> Year	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 25, 1891</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO. county</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas Henry Lester</u>		14. MOTHER'S MAIDEN NAME <u>Emma Watson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>101-111111</u>	
17. INFORMANT <u>Son, Robert Langley</u>		Address <u>Severna Park Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal Hemorrhage</u> DUE TO <u>Generalized Carcinomatosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1956</u> , 19 <u>56</u> , to <u>6-7-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6-7-58</u> , 19 <u>58</u> , and that death occurred at <u>4:20 P.M.</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Robert R. HAHN</u>		ADDRESS (Street, city or town, state) <u>Severna Park Md</u> DATE SIGNED <u>6-7-58</u>	
PHYSICIAN'S NAME (Type) <u>1</u>		<u>Robert R. HAHN</u> Severna Park Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 10, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Langley</u>		ADDRESS <u>Glen Burnie, Md.</u>	
24a. REC'D BY REGISTRAR <u>MIN 9</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

06430

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and the nearest town) <i>Millicentville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie Md</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>James Nursing Home</i>		d. STREET ADDRESS <i>604 Newfield Road</i>	
3. NAME OF DECEASED (Type or print) First <i>Battie</i> Middle <i>Rebecca</i> Last <i>Langsville</i>		DATE OF DEATH Month <i>June</i> Day <i>11</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/19/1884</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>
13. FATHER'S NAME <i>James Burgan</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Faulkner</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <i>no</i>		17. INFORMANT Address <i>none</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>General Carcinomatosis.-</i> DUE TO <i>Carcinoma of Uterus with</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>metastasis.-</i> DUE TO (c) <i>metastasis.-</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hypertensive Cardio Vascular Disease - Left Hemiplegia</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>5/12</i> , 19 <i>58</i> to <i>6/11</i> , 19 <i>58</i> that I last saw the deceased alive on <i>6/19/58</i> , 19 <i>58</i> , and that death occurred at <i>3:35 p</i> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Febus Grauberg</i>		ADDRESS (Street, city or town, state) <i>10 Gill St. Odenton Md</i>	
PHYSICIAN'S NAME (Type) <i>Febus Grauberg</i>		DATE SIGNED <i>6/14/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>6/14/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>MT. OLIVE</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hopping & Birken</i>		24a. REC'D BY REGISTRAR <i>DATE JUN 13 '58</i>	
ADDRESS <i>Glen Burnie</i>		24b. REGISTRAR'S SIGNATURE <i>Archie</i>	

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Hydrogen peroxide (H₂O₂) is a colorless liquid with a sharp, irritating odor. It is used as a disinfectant and in various chemical reactions.

[Faint handwritten notes at the bottom of the page, likely bleed-through from the reverse side.]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6416

Form 7 Filed 7-7-58 et

Reg. Dist. No.

06431

1. PLACE OF DEATH a. COUNTY <u>ANNE.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ANNE.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arundel</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Annapolis General Hosp.</u>				d. STREET ADDRESS <u>309 Hookell Plr.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Charles A. Lettau</u>				4. DATE OF DEATH Month <u>6</u> Day <u>27</u> Year <u>1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Art. Glazier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Bellaire, Ohio</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Ernest D. Lettau</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Mangold</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Ernest G. Lettau, Arnold, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>484.4</u> IMMEDIATE CAUSE (a) <u>Caduce</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. L. Linhardt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. L. Linhardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-27-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 30 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. DeLoach</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6445

CERTIFICATE OF DEATH

06432

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie 5mth</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Plaza Manor Nursing Home</i>		d. STREET ADDRESS <i>27 N. Carey St.</i>	
3. NAME OF DECEASED (Type or print) First <i>Richard</i> Middle <i>Johnson</i> Last <i>Lewis</i>		4. DATE OF DEATH Month <i>6</i> Day <i>28</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Co.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-27-1875</i>
9. AGE (In years last birthday) <i>83</i> yrs.		10. IF UNDER 1 YEAR Months <i>8</i> Days <i>3</i>	10. IF UNDER 24 HRS. Hours <i>—</i> Min. <i>—</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Lib. Dir</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>Calvert Co., Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Lewis</i>		14. MOTHER'S MAIDEN NAME <i>Mary Snowden</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Harris Chambers - 2142 Aiken Street</i>		Address <i>—</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>General Carcinomatosis</i> DUE TO <i>Carcinoma of Bladder</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>—</i> DUE TO (c) <i>—</i>			INTERVAL BETWEEN ONSET AND DEATH <i>7 months</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hypertensive Cardiovascular Disease</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>	
20c. TIME OF INJURY Month <i>—</i> Day <i>19</i> Year <i>—</i> Hour <i>—</i> o. m. <i>—</i> p. m. <i>—</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) <i>—</i> (County) <i>—</i> (State) <i>—</i>
21. I certify that I attended the deceased from <i>4-2-1958</i> to <i>6-28-1958</i> , that I last saw the deceased alive on <i>6-21-1958</i> , and that death occurred at <i>3:30 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Febus Friedman</i> M.D.		ADDRESS (Street, city or town, state) <i>10 Guil St. Odeton Md.</i>	
PHYSICIAN'S NAME (Type) <i>Febus Friedman</i>		DATE SIGNED <i>6-28-1958</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>7-3-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles R. Law</i> ADDRESS <i>802 Madison Avenue</i>		24a. REC'D BY REGISTRAR <i>DUL 1 '58</i> 24b. REGISTRAR'S SIGNATURE <i>W. F. Smith</i>	

Calvert Co., Maryland

Harris Chambers - 2145 Aiken Street

No

Reg. Dist. No. **06433**

VS AIS (4)
ISM 9/SS



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6447

CERTIFICATE OF DEATH

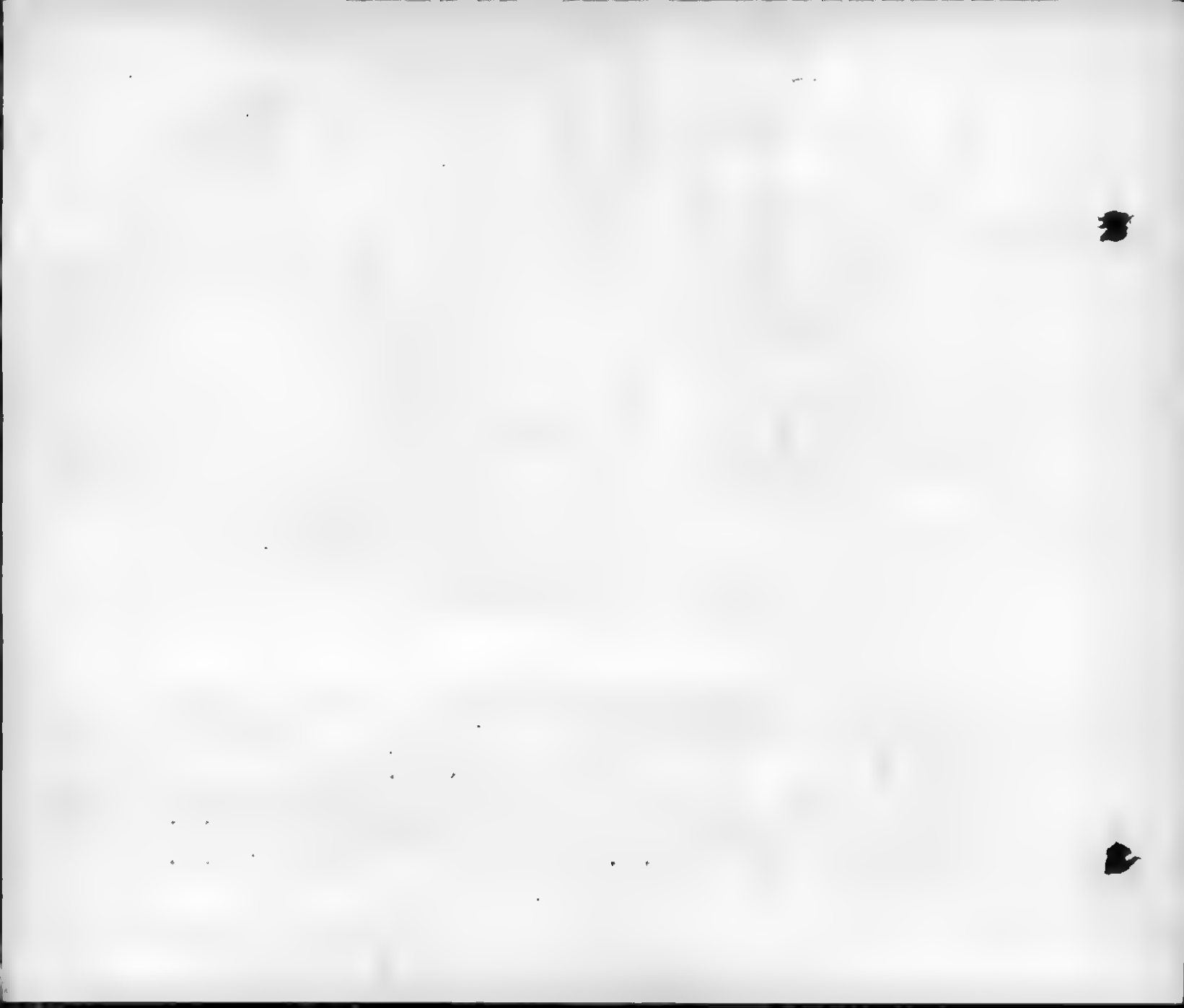
06434

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 6 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ Baltimore d. STREET ADDRESS 1516 Argyle Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Howard Matthews				4. DATE OF DEATH Month 6 Day 4 Year 19 58			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1896	
9. AGE (In years last birthday) 62 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 025X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Syphilitic and Arteriosclerotic Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome Associated with Arteriosclerosis.							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/28 , 19 58 , to 6/4 , 19 58 , that I last saw the deceased alive on 6/4 , 19 58 , and that death occurred at 10:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Crownsville State Hospital, Md.							
ACTUAL SIGNATURE Lionel McHenry Mapp				PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D. Crownsville State Hospital, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/9/58		22c. NAME OF CEMETERY OR CREMATORY Balto Nat'l Cem.		22d. LOCATION (City, town, or county) (State) 5501 Frederick Ave. Md	
23. FUNERAL DIRECTOR'S SIGNATURE Christington & Phillips Fun. Home				24a. REC'D BY REGISTRAR DATE JUN 10 '58		24b. REGISTRAR'S SIGNATURE Abraham	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 to 6 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 4 to 6 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 4 to 6 may be retained by the hospital or attending physician.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6448

CERTIFICATE OF DEATH

Reg. Dist. No. 06435

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Plaza Manor Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Edward Middleton</u>		4. DATE OF DEATH <u>6-7-1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-25-1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harvey Middleton</u>		14. MOTHER'S MAIDEN NAME <u>Ann</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Cousin</u>		Address <u>1204 Myrtle Ave Balt.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> 445X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardio Vascular Disease</u> (c) <u>Generalized Arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6-5-1958</u> to <u>6-7-1958</u> that I last saw the deceased alive on <u>6-5-1958</u> , and that death occurred at <u>3:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Febeus Grunberg</u> M.D.		ADDRESS (Street, city or town, state) <u>10 Gill St Odenton</u>	
PHYSICIAN'S NAME (Type) <u>Febeus Grunberg</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>6/11/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Vincent's Cem. Baltimore</u>	22d. LOCATION (City, town, or county) (State) <u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mr. Kate R. Williams</u>		24a. REC'D BY REGISTRAR <u>JUN 10 '58</u>	
Address <u>Schneider St</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Deuch</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. 10-11-1971
 2. 10-11-1971
 3. 10-11-1971
 4. 10-11-1971
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 7. 10-11-1971
 8. 10-11-1971
 9. 10-11-1971
 10. 10-11-1971

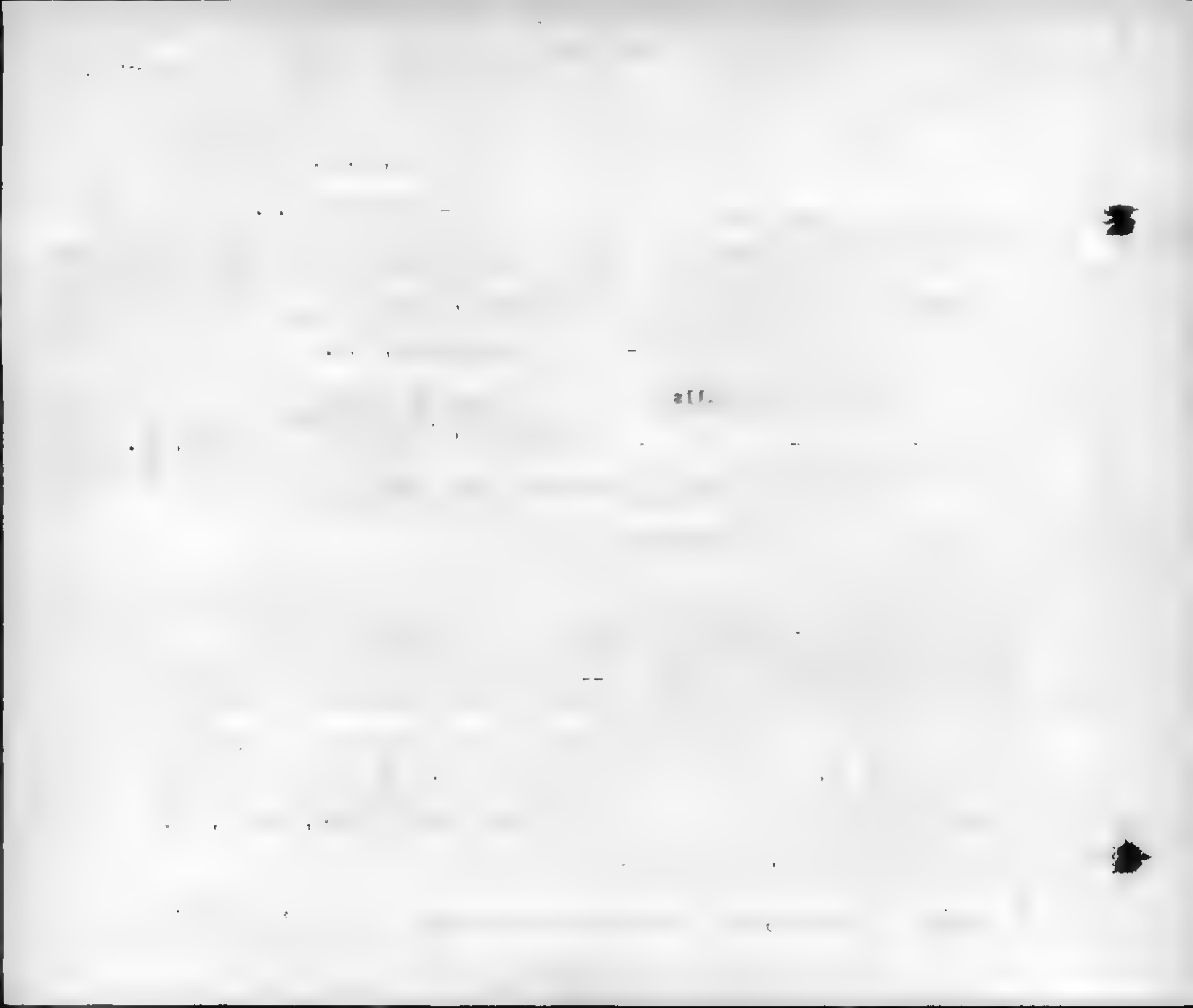
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1. The first part of the document is a list of names and dates, which appears to be a record of some kind. The names are written in a cursive script, and the dates are in a more formal, printed style. The list is organized into two columns, with names on the left and dates on the right.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 10/57

MARYLAND, STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
6449									
CERTIFICATE OF DEATH									
Reg. Dist. No. 06436									
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington, D. C. b. COUNTY 4				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel					c. LENGTH OF STAY IN 1b 4 months				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION District Training School					d. STREET ADDRESS 5100 - 2nd Street N.W.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Hunter Middle Jay Last Mills			4. DATE OF DEATH Month June Day 26 Year 1958						
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8, 1955	9. AGE (In years last birthday) 3 yrs	IF UNDER 1 YEAR Months 3 Days 26 Hours 19 Min 58				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) --		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Washington, D.C.					
12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME William Grady Mills			14. MOTHER'S MAIDEN NAME Peggy Ann England						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) --		16. SOCIAL SECURITY NO. --		17. District Training School Address Children's Center Laurel, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardio-vascular collapse secondary to 299X DUE TO aspiration Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost Post erythroblastosis (b) Post erythroblastosis (c) Post erythroblastosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral palsy with severe mental retardation 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) --									
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) --		20c. TIME OF INJURY Month, Day, Year February 14, 1958 to June 26, 1958							
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Children's Center, Laurel, Md.							
20f. (City or town) Laurel (County) Maryland (State) Md.									
21. I certify that I attended the deceased from June 26, 1958 , that I last saw the deceased alive on June 26, 1958 , and that death occurred at 9:00 A.M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) Children's Center, Laurel, Md. DATE SIGNED June 27, 1958									
ACTUAL SIGNATURE Wilfred R. Ehrmantraut, M.D.									
PHYSICIAN'S NAME (Type) Wilfred R. Ehrmantraut, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 27, 1958		22c. NAME OF CEMETERY OR CREMATORY District Training School					
22d. LOCATION (City, town, or county) Laurel, Maryland		(State) Md.							
23. FUNERAL DIRECTOR'S SIGNATURE John J. Dooney Jr.		24a. REC'D BY REGISTRAR JUL 2 '58		24b. REGISTRAR'S SIGNATURE Alb. Esch					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6417

CERTIFICATE OF DEATH

Reg. Dist. No.

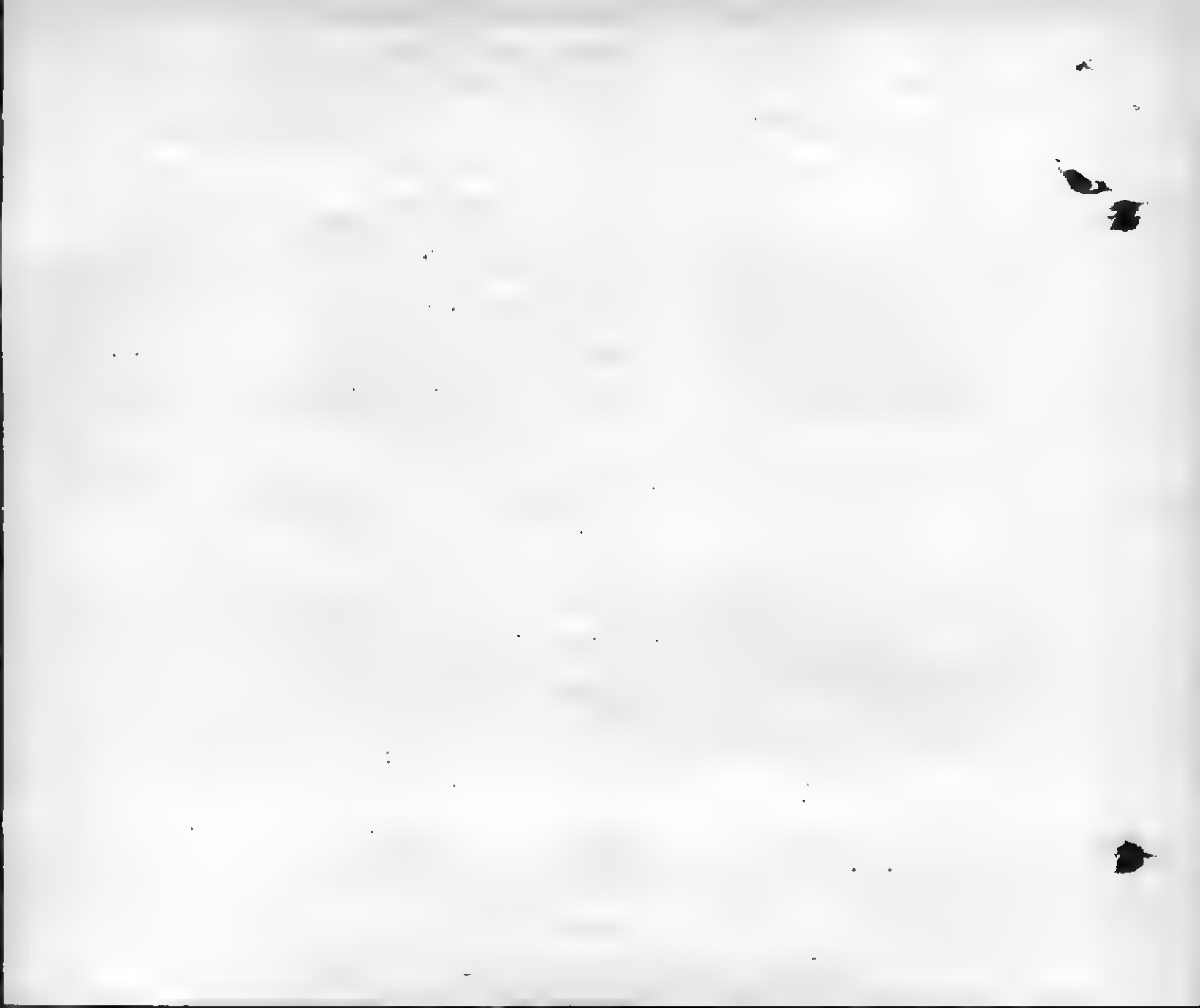
06437

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>2 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>108 College Creek Terrace</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Matthew</u> Middle <u>(n)</u> Last <u>MOORE Jr.</u>		4. DATE OF DEATH Month <u>June</u> Day <u>18</u> Year <u>1958</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 18, 1958</u>		9. AGE (In years last birthday) yrs. <u>2</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>5</u> Hours <u>5</u> Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Matthew MOORE</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Virginia HICKS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Hospital Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Erythroblastosis fetalis</u> <u>7'10 5</u> DUE TO <u>ABO incompatibility ??</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hydrops fetalis - prematurity</u>						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 <u>58</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 18</u> , 19 <u>58</u> , to <u>June 18</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>June 18</u> , 19 <u>58</u> , and that death occurred at <u>8:05</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>110 Clay St., Annapolis, Maryland</u> DATE SIGNED <u>June 19, 1958</u>							
ACTUAL SIGNATURE <u>R. L. Richardson</u>		M.D. <u>110 Clay St., Annapolis, Maryland</u>					
PHYSICIAN'S NAME (Type) <u>R. L. Richardson</u>							
22a. BURIAL, CREMATION, REMOVAL (Spec by) <u>Burial</u>		22b. DATE THEREOF <u>6-19-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill Cemetery, Annapolis, Md.</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Beckett</u>		ADDRESS <u>108 Wash St. Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>W. Beckett</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beckett</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be relayed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6418

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>aa</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>aa</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Edgewater R.F.D. #3</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>A. A. General Hospt.</i>		d. STREET ADDRESS <i>Annapolis</i>	
3. NAME OF DECEASED (Type or print) First <i>James</i> Middle <i>William</i> Last <i>Moulden</i>		4. DATE OF DEATH Month <i>6</i> Day <i>22</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-5-1908</i>
9. AGE (In years last birthday) <i>49</i> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Machine Operator Construction</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>M. S. A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Fredrick W. Moulden</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Martin</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>214-03-8634</i>	
17. INFORMANT <i>Eva Kathryn Moulden</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO <i>Generalized Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized Arteriosclerosis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>6 min.</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office-bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>6-5-58</i> to <i>6-22-58</i> , that I last saw the deceased alive on <i>6-6-58</i> , and that death occurred at <i>2:50 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frank M. Shipley</i>		ADDRESS (Street, city or town, state) <i>121 Cathedral St</i>	
DATE SIGNED <i>6-23-58</i>		PHYSICIAN'S NAME (Type) <i>Frank M. Shipley Annapolis, Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6-25-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Hill Crest Cent</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		ADDRESS <i>Annapolis Md</i>	
24a. REC'D BY REGISTRAR <i>DATE JUN 24 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. Beach</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6450 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06439

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

M

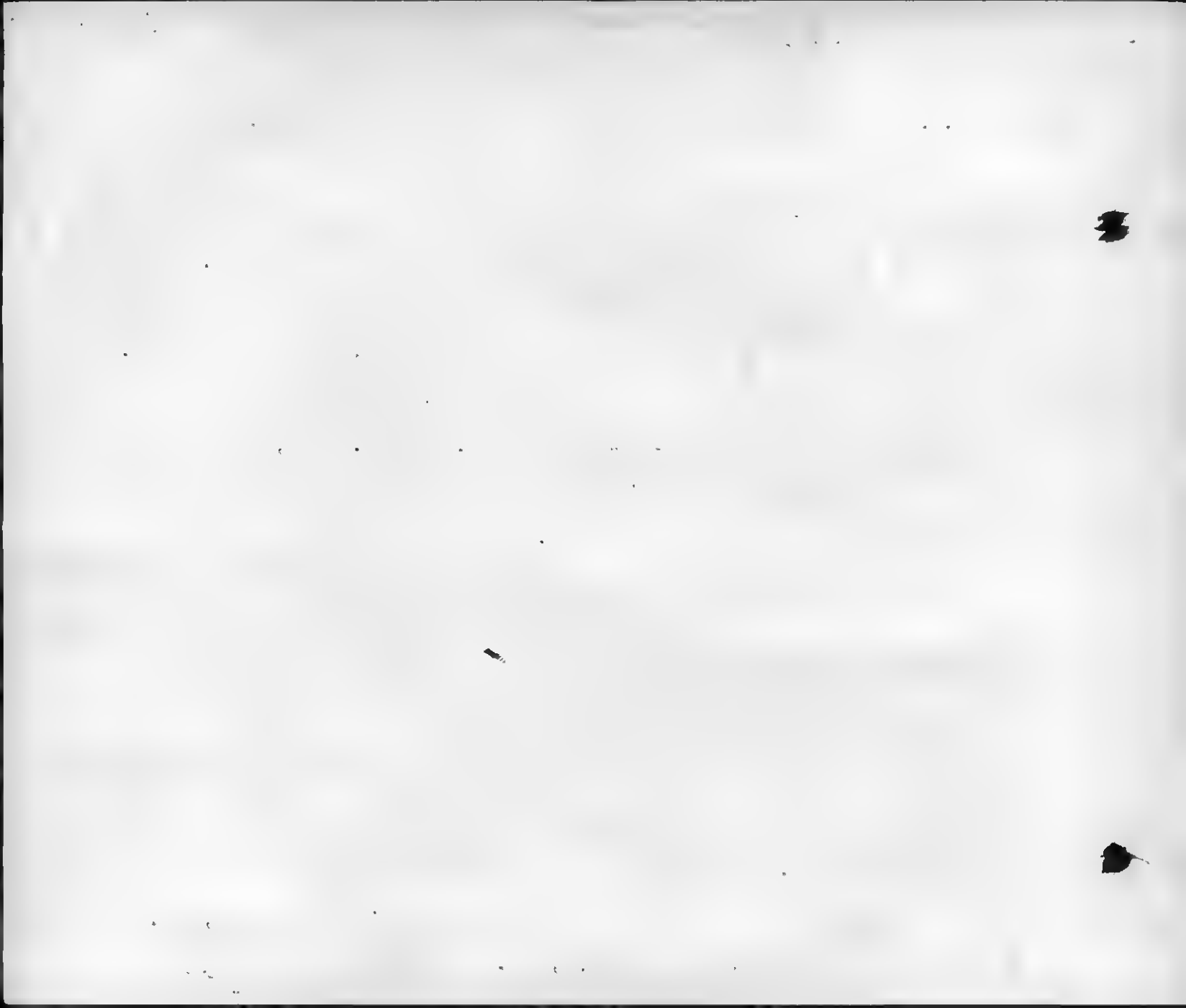
I

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH a. COUNTY <u>A.A.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN 1b <u>Unknown</u>			2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Country Club Estate, Glen Burnie</u>		
3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>66 West Side of Cedar Avenue</u>			4. DATE OF DEATH Month <u>June</u> Day <u>21st.</u> Year <u>1958</u>		
5. NAME OF DECEASED (Type or print) <u>James Willis Munch</u>			6. IS RES DECEASED ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/2/04</u>	9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bridge Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ridgeland, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>W.A. Munch</u>			14. MOTHER'S MAIDEN NAME <u>Emily B. Janette</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>231-09-7909</u>		17. INFORMANT <u>James W. Munch Jr. (son), same as 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Self Inflamed wound to the brain with a</u> <u>776x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>22 caliber rifle.</u> (c) <u> </u> DUE TO (a) <u> </u> (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> (b) <u> </u> (c) <u> </u>					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>See # 18</u>			
20c. TIME OF INJURY Month, Day, Year <u>6/21/58</u> Hour <u> </u> m. <u> </u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Cedar Avenue</u>	20f. (City or town) <u>Glen Burnie, Md.</u>	(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>June 22 1958</u>	
22a. BURIAL, CREMATION OR REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>6/24/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Crematorium</u>		22d. LOCATION (City, town, or county) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kirkley</u>		ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u> </u>	24b. REGISTRAR'S SIGNATURE <u> </u>

DATE JUN 25 '58



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6451

CERTIFICATE OF DEATH

06440

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 18 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. STREET ADDRESS 1801 Madison Avenue			
3. NAME OF DECEASED (Type or print) First Florence Middle Burket Last Nichols				4. DATE OF DEATH Month 6 Day 27 Year 19 58			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 11, 1913		9. AGE (In years last birthday) 44 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Rice Burket			
14. MOTHER'S MAIDEN NAME Margaret				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Unknown			
16. SOCIAL SECURITY NO None				17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia 332 X DUE TO Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebral Thrombosis DUE TO (c) Generalized Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 10:00 A				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	
20f. (City or town) —				20g. (County) —		20h. (State) —	
21. I certify that I attended the deceased from 6/9 , 19 58 to 6/27 , 19 58 , that I last saw the deceased alive on 6/27 , 19 58 , and that death occurred at 10:00 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Lionel McHenry Mapp</i>				ADDRESS (Street, city or town, state) Crownsville State Hospital, Md.			
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D.				DATE SIGNED Crownsville State Hospital, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-2-58		22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles R Law</i>				ADDRESS <i>802 Madison Ave</i>		24a. REC'D BY REGISTRAR JUL 1 '58	
24b. REGISTRAR'S SIGNATURE <i>Albert</i>							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6452

CERTIFICATE OF DEATH

Reg. Dist. No. **06441**

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>85 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City 3401-4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Plaza Manor Nursing Home</u>				d. STREET ADDRESS <u>939 W. Fayette</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George</u> First Middle Last				4. DATE OF DEATH <u>June 26</u> Month Day Year <u>1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-1-1884</u>	
9. AGE (In years last birthday) <u>73</u> yrs		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>		IF UNDER 24 HRS Hours <u>—</u> Min <u>—</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shop factory worker</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Lincoln Co., Georgia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jessy Parks</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-05-3257</u>		17. INFORMANT <u>Ernest Hawkins</u> Address <u>939 W. Fayette Street</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Sub Arachnoid Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Left Hemiplegia Post. Cerebral Vascular</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Accident</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-1</u> , 19 <u>57</u> , to <u>6-29</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6-25</u> , 19 <u>58</u> , and that death occurred at <u>12:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John G. Gaunberg</u> M.D.				ADDRESS (Street, city or town, state) <u>10 Gill St. Odenton Md</u>			
PHYSICIAN'S NAME (Type) <u>John G. Gaunberg</u>				DATE SIGNED <u>June 26-1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-28-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u> ADDRESS <u>802 Madison Avenue</u>				24a. REC'D BY REGISTRAR <u>JUN 30 58</u> 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6419

CERTIFICATE OF DEATH

06442

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. General Hspt.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>E</u> Last <u>POOLE</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>28</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB - 6 - 1910</u>
9. AGE (In years last birthday) <u>48</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EVEREST H. POOLE</u>		14. MOTHER'S MAIDEN NAME <u>VIOLET S. THOMAS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Richard Poole Edgewater Md Co. 4d.</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>57</u> , to <u>June 28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>May 20</u> , 19 <u>58</u> , and that death occurred at <u>6:12</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John C. Hedeman</u> M.D.		ADDRESS (Street, city or town, state) <u>629 1/2</u> DATE SIGNED <u>6/29/58</u>	
PHYSICIAN'S NAME (Type) <u>—</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>6-30-58</u>		22b. DATE THEREOF <u>—</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Son Annapolis Md.</u>		24a. REC'D BY REGISTRAR <u>—</u> 24b. REGISTRAR'S SIGNATURE <u>—</u>	
DATE <u>JUL 1 '58</u>		DATE <u>—</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

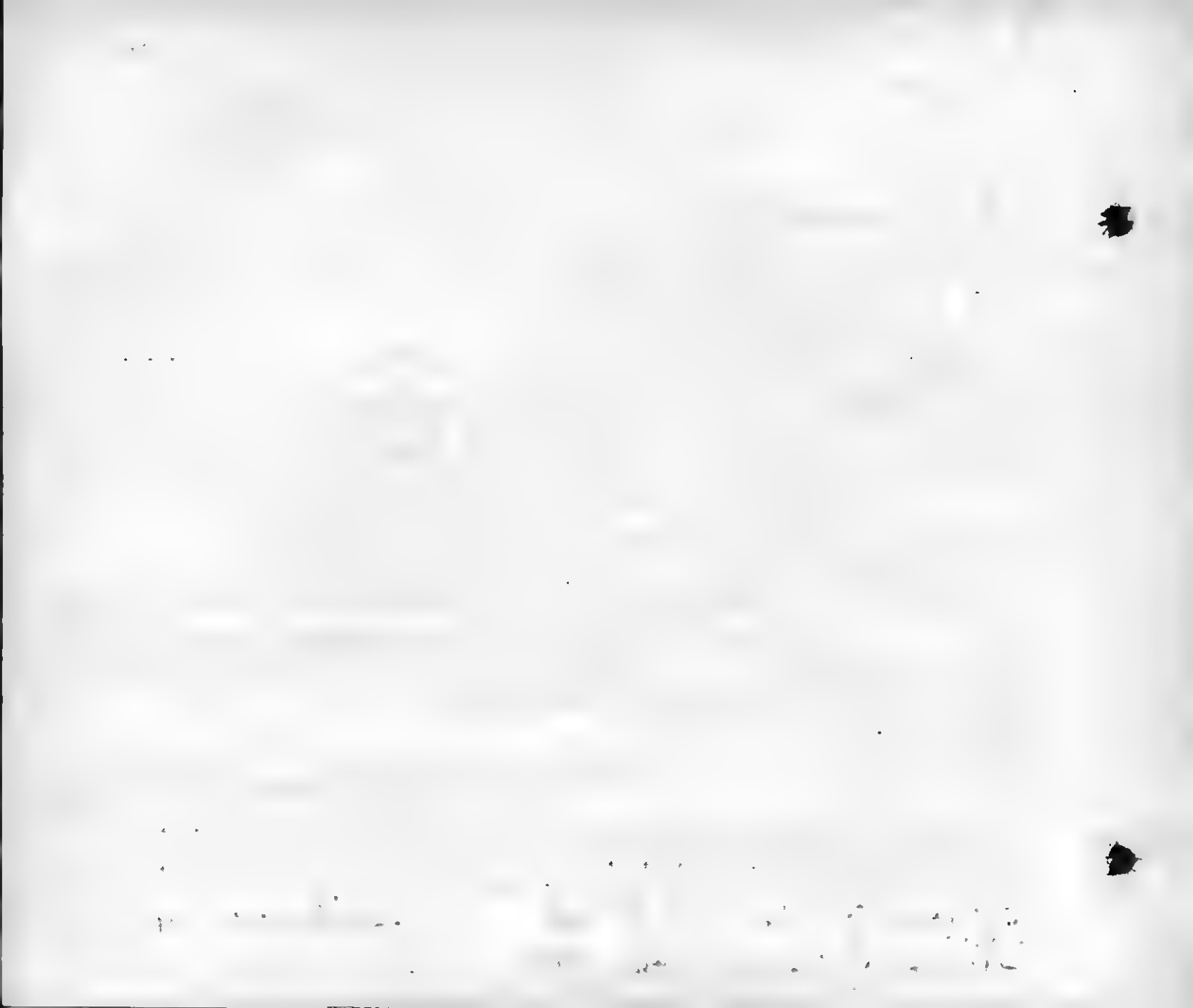
6453

CERTIFICATE OF DEATH

Reg. Dist. No.

06443

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownville c. LENGTH OF STAY IN 1b 11m 21d d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY East. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2045 N. East Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George Edgar Queen		4. DATE OF DEATH Month 6 Day 9 Year 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1893
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebrovascular Accident DUE TO (c) Carcinoma of the Prostate with Metastases PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardiac Decompensation with Pulmonary Edema INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/18 , 19 57 , to 6/9 , 19 58 , that I last saw the deceased alive on 6/9/58 , 19 _____, and that death occurred at 7:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownville State Hospital, Md. DATE SIGNED 6/10/58 ACTUAL SIGNATURE Lionel McHenry Mapp PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M. D. Crownville State Hospital, Md. 6/10/58			
22a. RURAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 6-11-58	
22c. NAME OF CEMETERY OR CREMATORY U. of Md.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese, Jr. - Ann. Md.		24a. REC'D BY REGISTRAR DATE JUN 13 '58	
24b. REGISTRAR'S SIGNATURE W. Reese			



6454

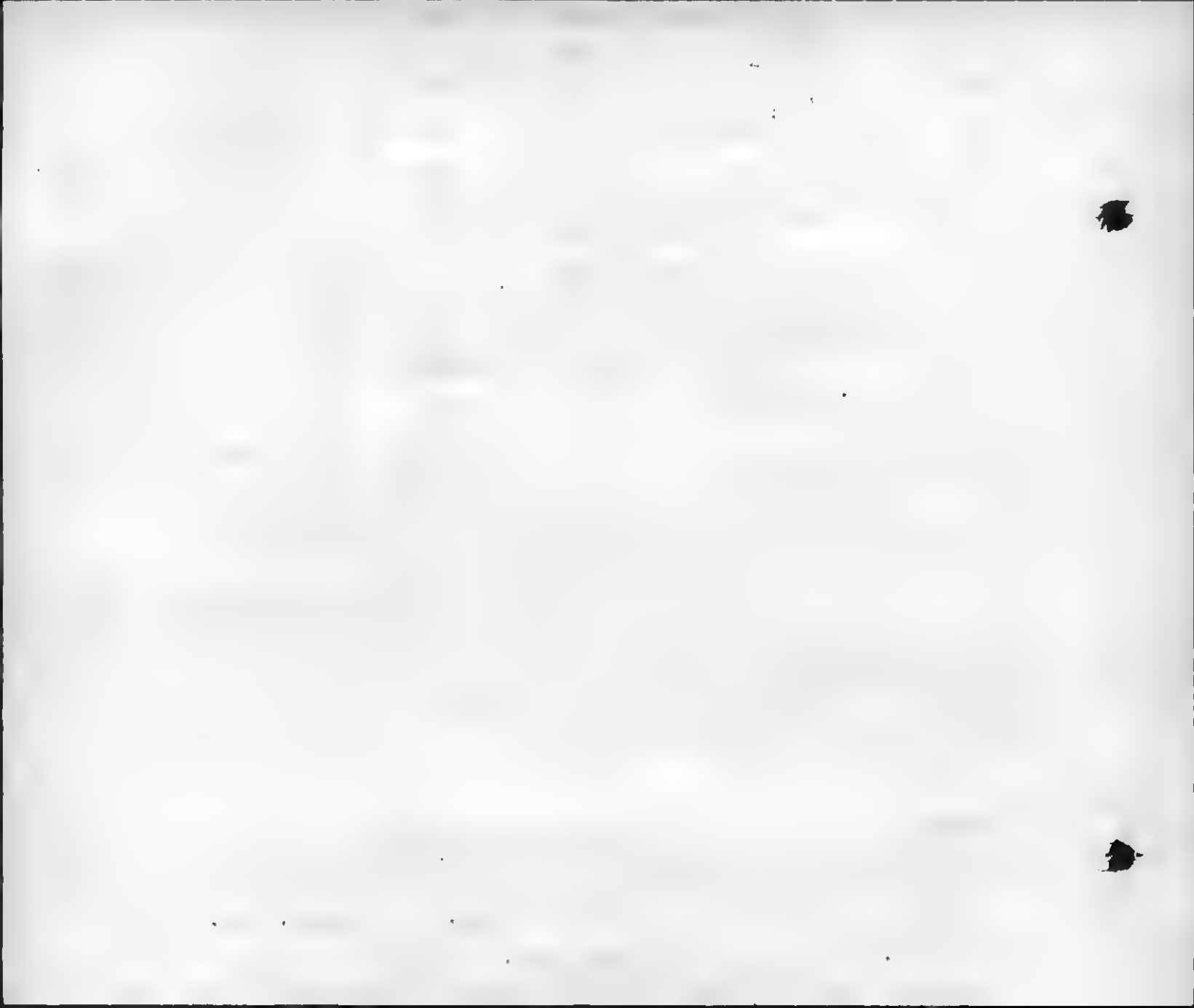
CERTIFICATE OF DEATH

06444

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hickwoodale Circle</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Antoinette</u> Last <u>Rand</u>		4. DATE OF DEATH Month <u>6</u> Day <u>11</u> Year <u>1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 7, 1880</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR: Months <u>11</u> Days <u>11</u> Hours <u>19</u> Min <u>55</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Boston, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Richard H. Rand</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>2445</u>	
17. INFORMANT <u>Daughter</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Generalized Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1954</u> , 19 <u>54</u> , to <u>6-11-55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6-11-55</u> , 19 <u>55</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Robert R. Hann</u> M.D.		ADDRESS (Street, city or town, state) <u>Severna Park, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Robert R. Hann</u>		DATE SIGNED <u>6-11-55</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-14-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Louden Park Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u>		ADDRESS <u>4107 Wilkens Ave. 29</u>	
24a. REC'D BY REGISTRAR <u></u>		24b. REGISTRAR'S SIGNATURE <u></u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6420

CERTIFICATE OF DEATH

Reg. Dist. No. 1

06445

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. STATE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. LENGTH OF STAY IN 1b X STERWOOD FOREST	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ANNE ARUNDEL GENERAL HOSPITAL		d. STREET ADDRESS IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ALICE		4. DATE OF DEATH Month 6 Day 24 Year 1958	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR 5th 1876
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME BLANCHARD EMORY		14. MOTHER'S MAIDEN NAME MARY BOURKE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. W# DAVIDSON	
17. INFORMANT St. MARGARETS, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rupture myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis, generalized DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. Month 19 Day 19 Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-3- 19 56 to 6-23- 19 58 that I last saw the deceased alive on 6-28-58 , 19 58 , and that death occurred at 12-58A , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Frank M Shipley M.D. 101 Cathedral St 6-25-58			
PHYSICIAN'S NAME (Type) Frank M Shipley Annapolis Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 6-26-58	22c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor & Sons Annapolis Md.		24a. REC'D BY REGISTRAR DATE JUN 27 '58	
		24b. REGISTRAR'S SIGNATURE W. L. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or inhumation, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6455

CERTIFICATE OF DEATH

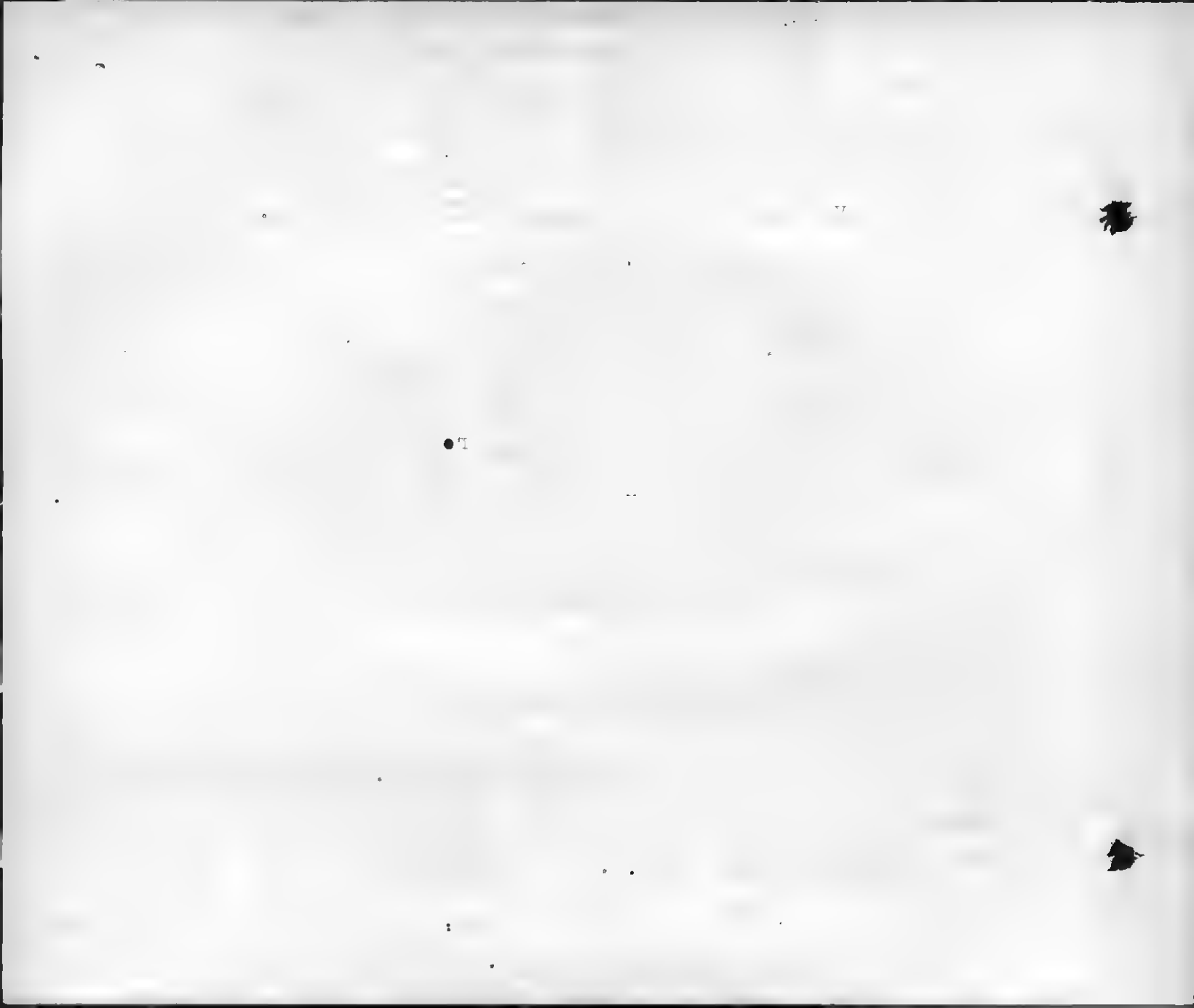
06446

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>		c. LENGTH OF STAY IN 1b <u>2 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Linthicum</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>#406 Oakgrove Road</u>				d. STREET ADDRESS <u>#406 Oakgrove Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>PHEBE</u> Middle <u>A.</u> Last <u>REINIG</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>22</u> Year <u>19 58</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 22/79</u>		9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Truscott</u>				14. MOTHER'S MAIDEN NAME <u>Maria Lotterrett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>none</u>		17. INFORMANT <u>Mrs. Carolyn Goetz</u>		Address <u>Same As #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 Cardio-Vascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1956</u> , 19 <u>June 22/19 58</u> , that I last saw the deceased alive on <u>June 14/19 58</u> , and that death occurred at <u>1:15 PM</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>6/23/58</u>							
ACTUAL SIGNATURE <u>Charles L. Ball</u> M.D. <u>X</u>				DATE SIGNED <u>6/23/58</u>			
PHYSICIAN'S NAME (Type) <u>Charles L. Ball, M.D.</u> <u>Linthicum Heights, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 24/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Laurel Grove Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Patterson, New Jersey</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Singleton</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 25 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Al. Search</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6456

CERTIFICATE OF DEATH

Reg. Dist. No.

06447

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11024 Manor Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Matilda Reynolds</u>		4. DATE OF DEATH <u>0</u> <u>21</u> <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1880</u>
9. AGE (In years last birthday) <u>78</u> yrs		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Howard Co., Maryland</u>
13. FATHER'S NAME <u>Peter Reynolds</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Reynolds</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		17. INFORMANT <u>Mable Hendericks - 2124 Mt. Holley</u> Address	
16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>Cerebral Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Hypertensive Cardio Vascular Disease</u> (b) <u>Hypertensive Cardio Vascular Disease</u> (c) <u>Hypertensive Cardio Vascular Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pericardial Effusion</u>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ 19 p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I attended the deceased from <u>6-13</u> , 19 <u>58</u> , to <u>6-21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6-13</u> , 19 <u>58</u> , and that death occurred at <u>3:52 P.M.</u> from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Edith C. Andrews</u> M.D. <u>10911 St. Edwards Rd -</u>		DATE SIGNED <u>June - 21 - 1958</u>	
PHYSICIAN'S NAME (Type) <u>Edith C. Andrews</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-26-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Locus Mission Church</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Co., Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law - 802 Madison Avenue</u> ADDRESS		24a. REC'D BY REGISTRAR <u>June 26 1958</u>	24b. REGISTRAR'S SIGNATURE <u>Deborah</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3 and be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

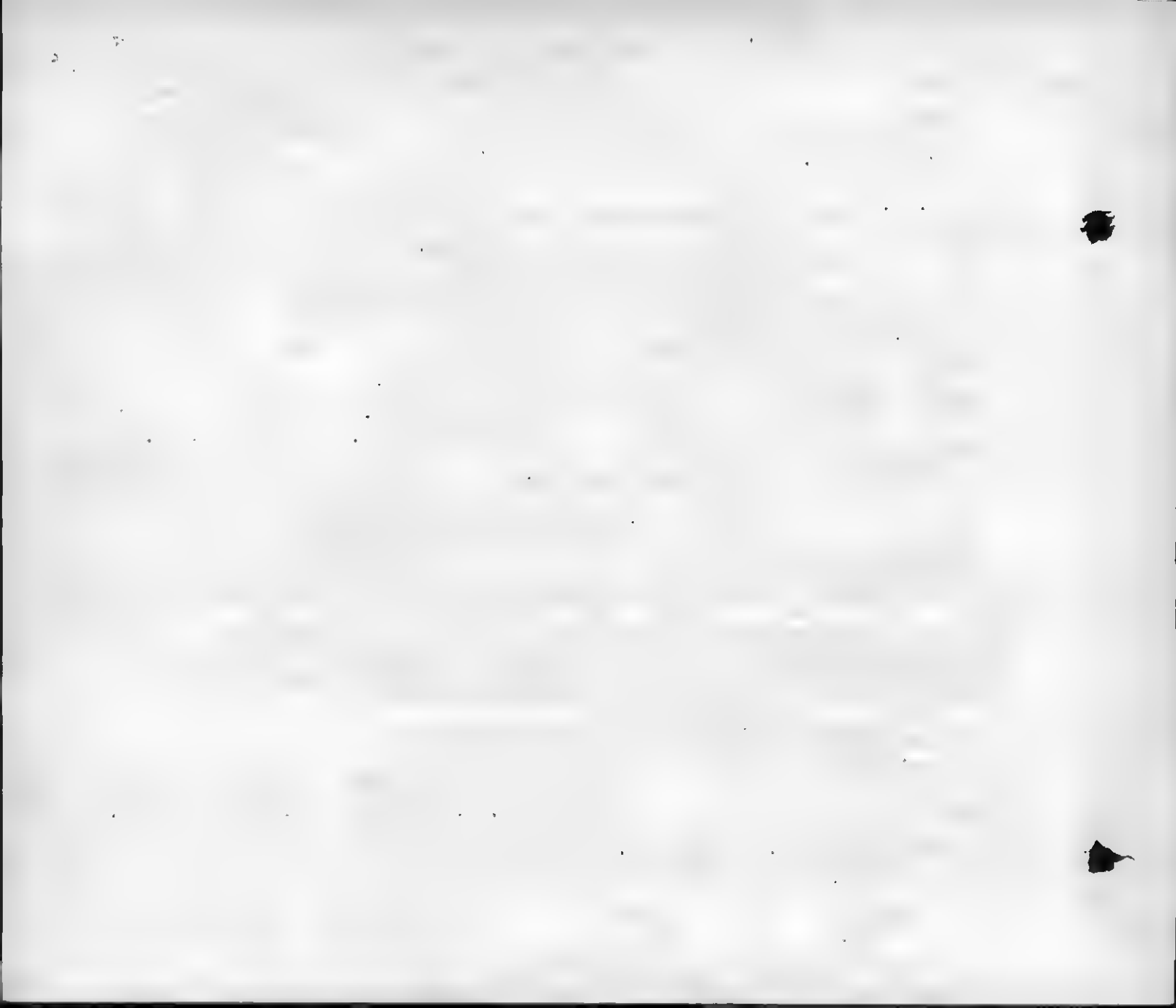
6457

CERTIFICATE OF DEATH

06448

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Oklahoma b. COUNTY Comanche			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade				c. LENGTH OF STAY IN 1b 3 months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. Army Hospital				d. STREET ADDRESS 1212 Carroll Drive			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Carolyn Middle Schneider Last Schneider				4. DATE OF DEATH Month June Day 20 Year 1958			
5. SEX Female		6. COLOR OR RACE caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8 September 1883	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 7 Days 20 Hours 19 Min.		IF UNDER 24 HRS. Months 7 Days 20 Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Henry Peusch				14. MOTHER'S MAIDEN NAME Lenora Grimm			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. unknown		17. INFORMANT Melva E. Viskocil (daughter) 223 Ferndale Rd., Glen Burnie, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral thrombosis 1143X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardiovascular disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 3 weeks							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that deceased was hospitalized from 27 May 58 to 20 June 58 that I last saw the deceased alive on 20 June 1958 , and that death occurred at 2300 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Raymond J. Gould M.D. U. S. ARMY HOSPITAL, FT. MEADE, MD. 20 Jun 58 PHYSICIAN'S NAME (Type) RAYMOND J. GOULD, CAPT., MC							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/24/58		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		22d. LOCATION (City, town, or county) (State) Brooklyn Rd 146	
23. FUNERAL DIRECTOR'S SIGNATURE H. V. Singleton				ADDRESS Glen Burnie, Md		24a. REC'D BY REGISTRAR DATE JUN 25 '58	
24b. REGISTRAR'S SIGNATURE Clifford							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6458

CERTIFICATE OF DEATH

Reg. Dist. No. 06449

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: <u>MD</u> b. COUNTY: <u>St. Louis Co</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Louis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Louis Hospital</u>				e. STREET ADDRESS <u>Cumpley Rd.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM E SCHULTZ</u>				4. DATE OF DEATH <u>June 5-1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 25-1904</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Road</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry F. Schultz</u>				14. MOTHER'S MAIDEN NAME <u>Ida E. Chase</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>218-34-6515</u>		17. INFORMANT <u>Ruby F. Schultz</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>58</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>6/17</u> , 19 <u>58</u> , to <u>6/15</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/15</u> , 19 <u>58</u> , and that death occurred at <u>10:10 AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) _____				DATE SIGNED <u>6/15/58</u>			
ACTUAL SIGNATURE <u>S. Borissnik</u>				M.D. <u>James G. Smith, M.D.</u>			
PHYSICIAN'S NAME (Type) <u>S. Borissnik</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 9-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Friendship</u>		22d. LOCATION (City, town, or county) (State) <u>St. Louis Co MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Blond G. Fink</u>				24a. REC'D BY REGISTRAR <u>Blond G. Fink</u>		24b. REGISTRAR'S SIGNATURE <u>Blond G. Fink</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be filled in by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be notified. Page 2 should be filled with the name of the funeral home to which the body is to be taken. Page 3 should be filled with the name of the funeral home to which the body is to be taken. Page 4 should be filled with the name of the funeral home to which the body is to be taken. Page 5 should be filled with the name of the funeral home to which the body is to be taken. Page 6 should be filled with the name of the funeral home to which the body is to be taken. Page 7 should be filled with the name of the funeral home to which the body is to be taken. Page 8 should be filled with the name of the funeral home to which the body is to be taken. Page 9 should be filled with the name of the funeral home to which the body is to be taken. Page 10 should be filled with the name of the funeral home to which the body is to be taken. Page 11 should be filled with the name of the funeral home to which the body is to be taken. Page 12 should be filled with the name of the funeral home to which the body is to be taken. Page 13 should be filled with the name of the funeral home to which the body is to be taken. Page 14 should be filled with the name of the funeral home to which the body is to be taken. Page 15 should be filled with the name of the funeral home to which the body is to be taken. Page 16 should be filled with the name of the funeral home to which the body is to be taken. Page 17 should be filled with the name of the funeral home to which the body is to be taken. Page 18 should be filled with the name of the funeral home to which the body is to be taken. Page 19 should be filled with the name of the funeral home to which the body is to be taken. Page 20 should be filled with the name of the funeral home to which the body is to be taken. Page 21 should be filled with the name of the funeral home to which the body is to be taken. Page 22 should be filled with the name of the funeral home to which the body is to be taken. Page 23 should be filled with the name of the funeral home to which the body is to be taken. Page 24 should be filled with the name of the funeral home to which the body is to be taken. Page 25 should be filled with the name of the funeral home to which the body is to be taken. Page 26 should be filled with the name of the funeral home to which the body is to be taken. Page 27 should be filled with the name of the funeral home to which the body is to be taken. Page 28 should be filled with the name of the funeral home to which the body is to be taken. 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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6459

CERTIFICATE OF DEATH

06450

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Round Bay, R.R. Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> <u>Rural</u>	c. LENGTH OF STAY IN 1b <u>20 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>L.</u> Last <u>Siegel</u>		4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 25, 1901</u>
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Model</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Modesty clerk</u>	11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Eustace A. Schoening</u>	
14. MOTHER'S MAIDEN NAME <u>Welchman?</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Wm. Siegel</u> Address <u>Severna Park R.R. Co Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Lungs & Lungs</u> DUE TO (b) <u>Carcinoma of the Intestines</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>
21. I certify that I attended the deceased from <u>June 16, 1958</u> , to <u>June 17, 1958</u> , that I last saw the deceased alive on <u>June 16, 1958</u> , and that death occurred at <u>12:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James S. Billingsley</u> M.D.		ADDRESS (Street, city or town, state) <u>102 Cedar St</u> DATE SIGNED <u>John Barnes Not June 7, 1958</u>	
PHYSICIAN'S NAME (Type) <u>John M. Saylor</u>		22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>	
22b. DATE THEREOF <u>6-18-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Ann's</u>	
22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 18 '58</u>	
24b. REGISTRAR'S SIGNATURE <u> </u>			

MEDICAL CERTIFICATION

VS A15 (4) 15M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06451

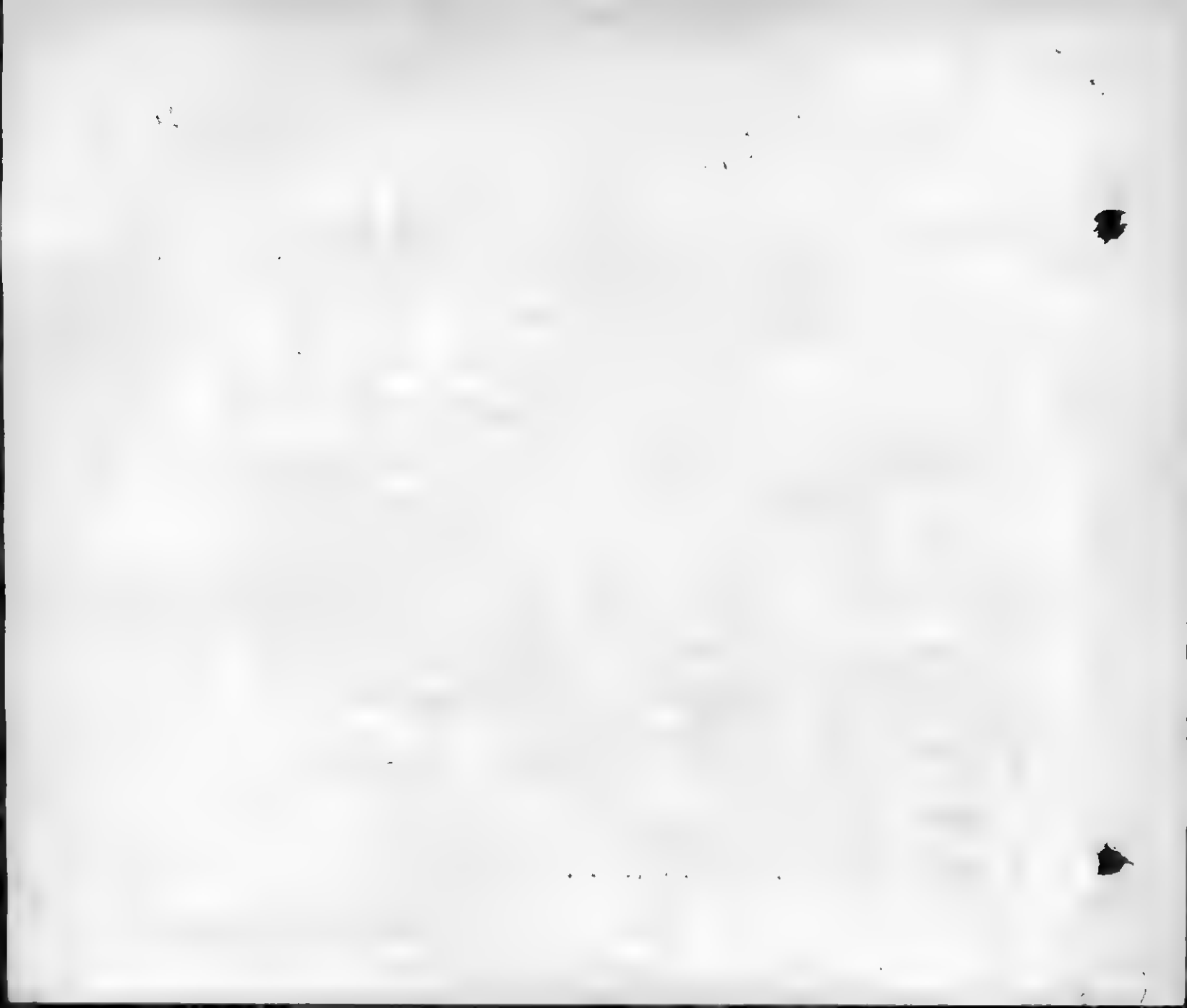
Reg. Dist. No.

6460

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mayo Md		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS Route 214	
3. NAME OF DECEASED (Type or print) ROBERT SELLMAN		4. DATE OF DEATH Month June Day 22 Year 19 58	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-6-1926
9. AGE (In years last birthday) 32 yrs		10. UNDER 1 YEAR Months Days	
11. UNDER 24 HRS Hours Min		12. CITIZEN OF WHAT COUNTRY U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Henry Sellman		14. MOTHER'S MAIDEN NAME Margaret Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 213-22-0002	
17. INFORMANT Margaret Sellman Mayo Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 241X DUE TO Bronchial Asthma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE William V. Lovitt, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/23/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-27-58	
22c. NAME OF CEMETERY OR CREMATORY Adams Chapel Bayand Md		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese #108 Wash. St. Annapolis		24a. REC'D BY REGISTRAR DATE JUL 2 '58	
24b. REGISTRAR'S SIGNATURE			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

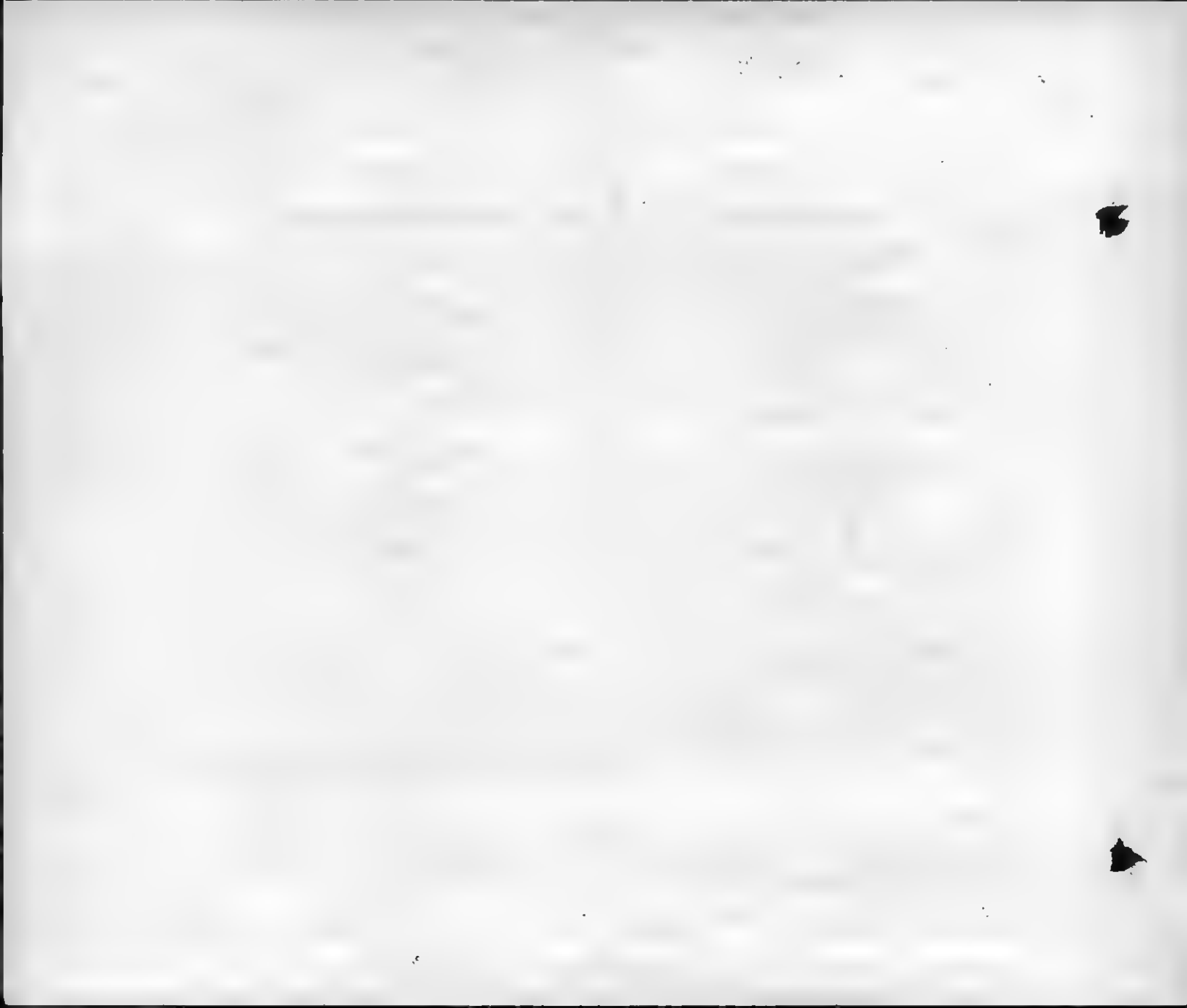
6461

CERTIFICATE OF DEATH

06452

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROOKLYN PARK</u>				c. LENGTH OF STAY IN 1b <u>31 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>212 ARUNDEL ROAD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY MARIE BARBARA Spiegel</u>				4. DATE OF DEATH Month Day Year <u>June 23 1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 6, 1906</u>	
9. AGE (In years last birthday) yrs. <u>51</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>FRANCIS X Schmitt</u>			
14. MOTHER'S MAIDEN NAME <u>MARY ANNA FRANZ</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT Address <u>August J Spiegel, 212 Arundel Rd A.A.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subacute bacterial endocarditis</u> <u>4/4x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatic heart disease</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>3/15</u> , 19 <u>57</u> , to <u>6/23</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/23</u> , 19 <u>58</u> , and that death occurred at <u>1:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Morton M. Krieger</u> M.D.				DATE SIGNED <u>5010A Ritchie Highway -25-</u>			
PHYSICIAN'S NAME (Type) <u>MORTON M. KRIEBER MD.</u>				ADDRESS (Street, city or town, state) <u>5010A RITCHIE HIGHWAY</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 26</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Bance</u>				ADDRESS <u>4001 Ritchie Hwy</u>		24a. REC'D BY REGISTRAR <u>30 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>George J. Bance</u>				24c. REGISTRAR'S SIGNATURE <u>George J. Bance</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6421

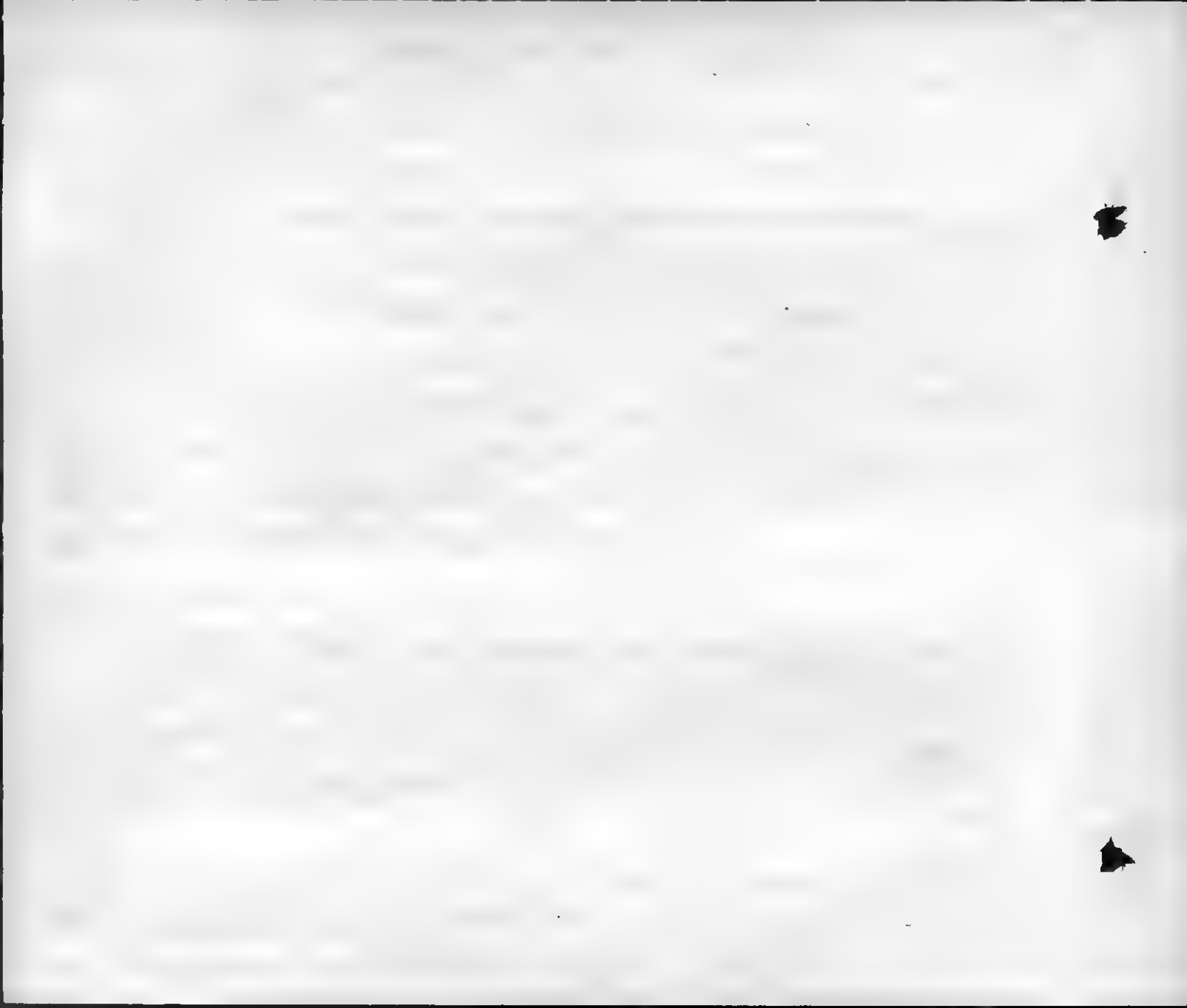
CERTIFICATE OF DEATH

Reg. Dist. No.

06453

1. PLACE OF DEATH o. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>U. A. General Hospt</u>		d. STREET ADDRESS <u>117 Academy St</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>D.</u> Last <u>Stanley</u>		4. DATE OF DEATH Month <u>6</u> Day <u>12</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-9-1901</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales. Eves Cola Bottling Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>7a</u>	
11. BIRTHPLACE (State or foreign country) <u>7a</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John C. Stanley</u>		14. MOTHER'S MAIDEN NAME <u>Martha Adams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>John D. Stanley</u>	
17. INFORMANT <u>John D. Stanley</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>John</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1, 1956</u> to <u>June 12, 1958</u> , that I last saw the deceased alive on <u>6-12-1958</u> , and that death occurred at <u>10:45 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>John D. Stanley</u> DATE SIGNED <u>6/13/58</u>			
ACTUAL SIGNATURE <u>John D. Stanley</u> M.D.		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REPAVOAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-15-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sins</u>		24a. REC'D BY REGISTRAR <u>June 16 '58</u>	
ADDRESS <u>Annapolis MD</u>		24b. REGISTRAR'S SIGNATURE <u>Overbaugh</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6422

CERTIFICATE OF DEATH

Reg. Dist. No. 06454

1. PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>AA</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Md</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>527 Second St.</i>		e. STREET ADDRESS <i>527 Second</i> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Myrtle Ann Stephen</i>		4. DATE OF DEATH <i>6-11-1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-7-1890</i>
9. AGE (In years last birthday) <i>68</i> yrs		IF UNDER 1 YEAR	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Annapolis Md</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Thomas Kelley</i>	
14. MOTHER'S MAIDEN NAME <i>Mary E. Wiggins</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>1</i>		17. INFORMANT <i>Carl F. Stephen #2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> <i>606x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Chronic pyelitis</i> DUE TO (c) <i>Neurogenic bladder</i>			INTERVAL BETWEEN ONSET AND DEATH <i>6 mos</i> <i>3 yrs</i> <i>5 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I, <i>John C. Hederman</i> , certify that I attended the deceased from <i>June 10</i> , 19 <i>58</i> , to <i>June 11</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>June 10</i> , 19 <i>58</i> , and that death occurred at <i>10:45</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John C. Hederman</i>		DATE SIGNED <i>6/13/58</i>	
PHYSICIAN'S NAME (Type) <i>Annapolis, Md.</i>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6-14-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Wellerest</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		24a. REC'D BY REGISTRAR <i>John M. Taylor</i>	
ADDRESS <i>Annapolis Md</i>		24b. REGISTRAR'S SIGNATURE <i>John M. Taylor</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6462

CERTIFICATE OF DEATH

06455

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel County			2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville			c. LENGTH OF STAY IN 1b 21y 5m 26d		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) First Middle Last Nelson Taylor			4. DATE OF DEATH Month Day Year 6 24 19 58		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1870	9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Charles Taylor			14. MOTHER'S MAIDEN NAME Eliza Hall		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) arteriosclerotic hypertensive cardiovascular disease DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) senile degeneration					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Crownsville			20g. (County) Harford		
21. I certify that I attended the deceased from January 6, 1955 , to June 24, 1958 , that I last saw the deceased alive on June 24, 1958 , and that death occurred at 1:15 AM , from the causes and on the date stated above.					
ACTUAL SIGNATURE Hildegard Reissmann			ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 6/24/58		
PHYSICIAN'S NAME (Type) Hildegard Reissmann, M. D.			Crownsville State Hospital, Md. 6/24/58		
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 6-25-58		22c. NAME OF CEMETERY OR CREMATORY St. Mary's	
22d. LOCATION (City, town, or county) Balto.		(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE William Reese, Jr. - Annapolis			24a. REC'D BY REGISTRAR 1 '58		
ADDRESS 1111			24b. REGISTRAR'S SIGNATURE Reese		

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

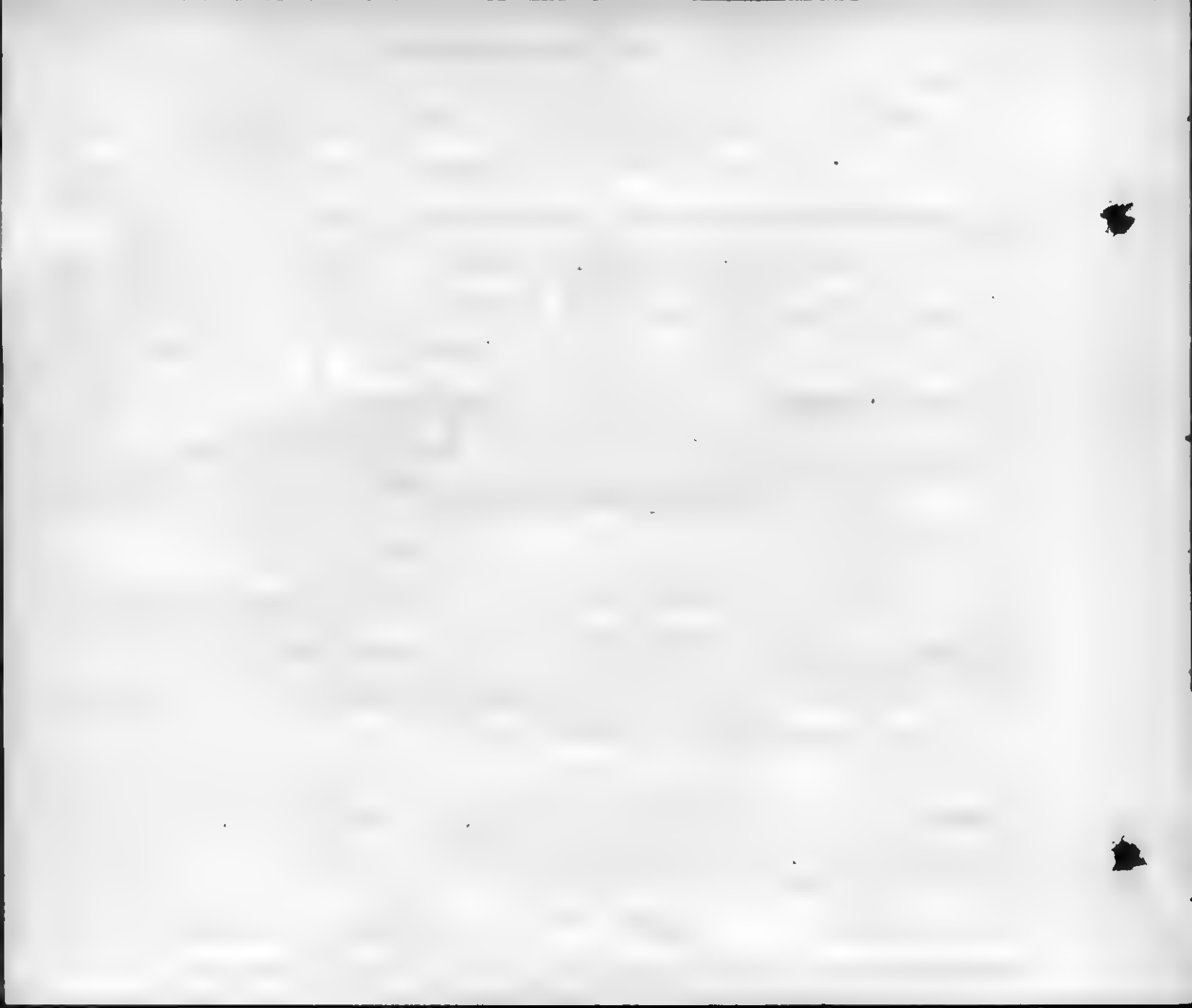
6463

CERTIFICATE OF DEATH

06456

Reg. Dist. No. 27

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Essex			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort George G. Meade				c. LENGTH OF STAY IN 1b 11 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U. S. ARMY HOSPITAL				d. STREET ADDRESS Caret			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last RYLAND EUGENE TAYLOR				4. DATE OF DEATH Month Day Year June 25 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 24 June 1911		9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William A. Taylor				14. MOTHER'S MAIDEN NAME Ida Collier			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 223-26-7972		17. INFORMANT Mrs Audrey P Dillard		Address Caret, Virginia (Sister)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBRO - VASCULAR ACCIDENT DUE TO CEREBRO-VASCULAR ACCIDENT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH 10 HOURS 10 Hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that the deceased was hospitalized at 1220PM 25 June 1958 , 19_____, that I last saw the deceased alive on 25 June 1958 , and that death occurred at 2333P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Samuel D. Gaby		M.D. U.S. ARMY HOSP, FT MEADE, MD		ADDRESS (Street, city or town, state) 25 Jun 58		DATE SIGNED	
PHYSICIAN'S NAME (Type) SAMUEL D. GABY, MD, US. ARMY HOSP, FT GEO G MEADE, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF JUNE-25-58		22c. NAME OF CEMETERY OR CREMATORY Upper Essex-Baptist Caret		22d. LOCATION (City, town, or county) (State) Essex Va.	
23. FUNERAL DIRECTOR'S SIGNATURE D. K. [Signature]				24a. REC'D BY REGISTRAR DATE JUN 30 '58		24b. REGISTRAR'S SIGNATURE [Signature]	



6423

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>aa</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>98 Shipwright</u>		d. STREET ADDRESS <u>198 Shipwright St.</u>	
3. NAME OF <u>ROGER</u> First Middle Last		4. DATE OF DEATH Month <u>6</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-6-1896</u>
9. AGE (In years last birthday) <u>62</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Archivist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W. Hall of Records</u>	
11. BIRTHPLACE (State or foreign country) <u>Cleveland Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Sebastian Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Mary Catherine Huntsberger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Elizabeth M. Thomas</u> Address <u>(2)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4-0-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1-4-</u> 19 <u>57</u> , to <u>6-16-</u> 19 <u>58</u> , that I last saw the deceased alive on <u>5-23-</u> 19 <u>58</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank M Shipley</u> M.D.		ADDRESS (Street, city or town, state) <u>121 Cathedral St. Annapolis, Md.</u> DATE SIGNED <u>6-19-58</u>	
PHYSICIAN'S NAME (Type) <u>Frank M Shipley</u>		<u>Annapolis, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>6-20-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u>	22d. LOCATION (City, town, or county) (State) <u>In Co. Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Scyglus</u> ADDRESS <u>Annapolis</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>JUN 23 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>—</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.



6424

CERTIFICATE OF DEATH

Reg. Dist. No. 06458

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b _____	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> 47X-3 ✓	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS <u>3031 Sedgwick St. N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>J. Frederick Wenchel</u> First Middle Last		4. DATE OF DEATH Month <u>6</u> Day <u>22</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/29/74</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? _____	
13. FATHER'S NAME <u>George Wenchel</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Gradwohl</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) _____		16. SOCIAL SECURITY NO. _____	
17. INFORMANT <u>Adam G. Wenchel</u> Address <u>3803 Blackthorn St. Chevy Chase, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO _____ (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>14 hrs.</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) _____	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____		20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. <u>19</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that I attended the deceased from <u>6-21</u> , 19 <u>58</u> , to <u>6-22</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6-21</u> , 19 <u>58</u> , and that death occurred at <u>4 P.</u> M. from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Frank M. Shipley</u> M.D. <u>121 Cathedral St</u> ADDRESS (Street, city or town, state) <u>Annapolis, Md.</u> DATE SIGNED <u>6-22-58</u>		PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/24/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		24a. REC'D BY REGISTRAR <u>June 24 1958</u>	
24b. REGISTRAR'S SIGNATURE <u>Deborah</u>		25. ADDRESS <u>2901 14th St. N.W. Washington 9, D.C.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with page 3 and detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
John Doe		45		Male		White		1925		Boston, Mass.	
Residence		Occupation		Cause of Death		Manner of Death		Physician		Hospital	
123 Main St.		Teacher		Heart Disease		Natural		Dr. Smith		St. Mary's	
Date of Birth		Date of Admission		Date of Discharge		Date of Death		Date of Burial		Date of Interment	
1910		1925		1925		1925		1925		1925	
Signature of Physician		Signature of Registrar		Signature of Burial Officer		Signature of Interment Officer		Signature of Death Officer		Signature of Death Officer	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, MA

6464

CERTIFICATE OF DEATH

06459

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Laurel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>				c. LENGTH OF STAY IN 1b <u>3 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR-INSTITUTION <u>Children's Center</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edward Jerome Young</u>				4. DATE OF DEATH Month Day Year <u>June 11 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/14/48</u>	
9. AGE (In years last birthday) <u>9</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Nipthornell Young</u>				14. MOTHER'S MAIDEN NAME <u>Garonia Pitts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, specify unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>130 2 4581</u>		17. INFORMANT <u>Nipthornell Young</u> Address <u>1302 St. N.E., Wash. D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dehydration</u> DUE TO <u>infectious diarrhea</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>7 days</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>cerebral birth injury with mental retardation</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>5/16</u> , 19 <u>58</u> to <u>6/11/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>6/11</u> , 19 <u>58</u> , and that death occurred at <u>8:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wilfred R. Ehrmantraut</u> M.D.				ADDRESS (Street, city or town, state) <u>Children's Center</u> DATE SIGNED <u>6/13/58</u>			
PHYSICIAN'S NAME (Type) <u>Wilfred R. Ehrmantraut</u>				<u>Laurel, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/16/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>D.T.S. cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel, Md. Anne Arundel</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Young Jr.</u> ADDRESS <u>Supt. D.T.S. Laurel, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

FILE NO.

DATE

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

PREVIOUS UNKNOWN

PREVIOUS MISCELLANEOUS

PREVIOUS OTHER

PREVIOUS UNKNOWN

PREVIOUS MISCELLANEOUS

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

PREVIOUS UNKNOWN

PREVIOUS MISCELLANEOUS

PREVIOUS OTHER

PREVIOUS UNKNOWN

PREVIOUS MISCELLANEOUS